

Medication List for name: _____, DOB:

Medication List

Prepared on date: _____



Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.




Note any changes to how you take your medications.
Cross out medications when you no longer use them.

Medication	How I take it	Why I use it	Prescriber



Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber

 **Allergies:**

 **Side effects I have had:**

Empty text area for reporting side effects.

 **Other information:**

Empty text area for providing other information.



My notes and questions:

Large empty text area for notes and questions.