Medication List

Name: _____ Date of Birth: _____ Last update: _____

Always keep this form with you. Please give a copy to your emergency contact. update this list when medications change. **Include ALL prescription drugs, over-the-counter medication, vitamins, eye drops, creams, herbal supplements, patches, inhalers, insulin, etc.**

	Medication Name (Copy name directly from bottle)	**Dosage** (2mg, 1tsp, 2 drops, etc)	**How Often** (Daily, Nightly, as needed, etc.)	**Time of day taken**	**Reason** (Why you are taking)	**Prescribing MD** (Prescriber)	**Currently Taking?**
	(**EXAMPLE**) Ibuprofen	400 mg	2x a day	1 p.m.	mild pain	Doctors name	☐Yes ☐No
1							☐Yes ☐No
2							☐Yes ☐No
3							☐Yes ☐No
4							☐Yes ☐No
5							☐Yes ☐No
6							☐Yes ☐No
7							☐Yes ☐No
8							☐Yes ☐No
9							☐Yes ☐No
10							☐Yes ☐No
11							☐Yes ☐No
12							☐Yes ☐No
13							☐Yes ☐No
14							☐Yes ☐No
15							☐Yes ☐No