MY MEDICATIONS

Name: _____ **Date:** _____

ALLERGIES:	My Doctor:_____Phone: _____ My Pharmacy: _____Phone: _____

List all your medications on this form. Share this with your doctor, nurse, pharmacist and caregivers

PRESCRIPTION MEDICINES

Name of Medicine	**Dose** (mg, ml, units, puffs, drops)	**When do I take this medicine?**					**Why do I take it?**
		AM	Noon	PM	Bed Time	With Food	

OVER-THE COUNTER MEDICINES (herbals, vitamins, antacids, aspirin, etc).

Name of Medicine	**Dose** (mg, ml, units, puffs, drops)	**When do I take this medicine?**					**Why do I take it?**
		AM	Noon	PM	Bed Time	With Food	