My Medication List

Name: _____ Physician: _____ Phone: _____
Address: _____ Physician: _____ Phone: _____
City: _____ State: _____ Zip: _____ Birthdate: _____ Physician: _____ Phone: _____
Emergency Contact: _____ Pharmacy: _____ Phone: _____
Relationship: _____ Phone: _____ Pharmacy: _____ Phone: _____
Medical History: _____
Drug Allergies:

Medication	Strength	How often?	Comments		Medication	Strength	How often?	Comments

*REMEMBER TO UPDATE YOUR MEDICATIONS – Mark out medications that are discontinued. Add new medications started.