Medication List

Information:

Name:	**Address:**
Phone number:	
Date of Birth:	
Emergency Contact/phone:	

Allergies

Allergic to:	Reaction:
Allergic to:	Reaction:
Allergic to:	Reaction:

List ALL medications you are currently taking: please include prescriptions, over-the-counter medications, and herbals. *Update with each visit to your provider.*

Drug Name	Directions: How I take this	I started taking this on:	I stopped taking this on:	Why I take this medication	Doctor's name