MY MEDICATION LIST

LAST UPDATED:

PATIENT INFO			
	Name:	**Primary Doctor:**	☎:
	Birth Date:	**Specialist(s):**	☎:
	☎:	**Primary Pharmacy:**	☎:
	Emergency Contact: (name & phone)	**Other Pharmacy(s):**	☎:

ALLERGIES	I'm allergic to:	I have this type of reaction:

List All Prescription Medications, Over-The-Counter Medications, Herbal Supplements or Vitamins you take
Continue on second page if needed

Name of Medication & Strength e.g. Mg, units, etc.	How I take my meds e.g. Take 1 tablet by mouth 2 times daily	Time of day					I'm taking or not taking this medication because...	Date Started	Date Stopped
		Morning	Afternoon	Evening	Before Bed	As Needed (PRN)			

This form is available for download or print at http://www.ucdmc.ucdavis.edu/pharmacy/MyMedicationsList.doc

Name of Medication & Strength e.g. Mg, units, etc.	How I take my meds e.g. Take 1 tablet by mouth 2 times daily	Time of day					I'm taking or not taking this medication because...	Date Started	Date Stopped
		Morning	Afternoon	Evening	Before Bed	As Needed (PRN)			

This form is available for download or print at http://www.ucdmc.ucdavis.edu/pharmacy/MyMedicationsList.doc