



**HOLY CROSS HOSPITAL**

# My Medication List

**Keep This Form in Your Wallet or Purse for Your Safety**

**How to Use “My Medication List”:** Use a pencil to record on this form your personal information, all the medicines you take and your allergies. Use your medication labels, your doctor, your family members, your pharmacists and your medication profile from your pharmacist to fill out this form completely. Always update this list with any additions or changes in your medicine and keep it with you at all times. Take this form with you to all health care visits. If you go to the hospital or your doctor for a planned procedure, take your medicines with you in their original bottles. If you need additional copies of this form, call **301.754.8800** or print them at **www.holycrosshealth.org**.

**How “My Medication List” Helps You:** This form will help you remember all of the medicines you take. It also provides your doctor and other health care providers with a current list of your medicines and why you take them. Knowing what medications you are taking helps the hospital and your doctors ensure you get the right medications, at the right dose, without interactions with your other medicines.

## PERSONAL INFORMATION

Name: \_\_\_\_\_ / \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Primary Physician/Phone Number: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Primary Pharmacy/Phone Number: \_\_\_\_\_  
Date I Last Updated This Form: \_\_\_\_\_ Emergency Contact/Phone Number: \_\_\_\_\_

## MY PRESCRIPTION MEDICATIONS

Start Date	Medication Name	Strength (e.g., 250 mg)	Directions for Use		Route/ Method (e.g., by mouth; inhaled; injectable; by eye drop)	When Do You Take This Medicine? (Check one)				Why Do You Take This Medicine?	Date of Change		Name and Number of the Physician who Prescribed this Medication	
			Dose (e.g., 2 pills or 1 puff)	How Often (e.g., once daily)		Morning	Noon	Dinner	Bedtime		As Needed	Stopped		Changed

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**MY MEDICATION ALLERGIES**

I am allergic to these medications:

This is the allergic reaction I have to these medications:

_____	_____
_____	_____
_____	_____
_____	_____

**MY OVER-THE-COUNTER MEDICINES**

I take the following over-the-counter medicines (e.g., aspirin, antacids):

Frequency:

Dose:

_____	_____
_____	_____
_____	_____
_____	_____

**MY HERBAL MEDICINES**

I take the following herbal medicines (e.g., ginseng, ginkgo):

Frequency:

Dose:

_____	_____
_____	_____
_____	_____
_____	_____

**MY VACCINES**

I have had the following vaccinations:

Date(s):

Pneumococcal (pneumonia)

Influenza (flu)

Tetanus

_____	_____
_____	_____
_____	_____

**MY VITAMINS**

I take the following vitamins:

Dose:

Frequency:

_____	_____
_____	_____
_____	_____
_____	_____