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: _____ **Primary Physician/Phone Number:** _____/_____

Phone Number: _____ **Primary Pharmacy/Phone Number:** _____/_____

Birth Date: _____ **Emergency Contact/Phone Number:** _____/_____

Date I Last Updated This Form: _____

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	

See other side for additional information.

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):	Dose:	Frequency:

MY HERBAL MEDICINES

I take the following herbal medicines (e.g., ginseng, gingko):	Dose:	Frequency:

MY VACCINES

I have had the following vaccinations:	Date(s):
Pneumococcal (pneumonia)	
Influenza (flu)	
Tetanus	

MY VITAMINS

I take the following vitamins:	Dose:	Frequency:

See other side for additional information.