Medication List

Member Name: INSERT MEMBER NAME

Date of Birth: INSERT MEMBER DOB

Prepared on: INSERT DATE

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications. Cross out medications when you no longer use them.

Medication	How I take it	Why I use it	Prescriber
Insert generic name and brand name, strength, and dosage form for current/active medications	*Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate*	*Insert indication or intended medical use*	*Insert prescriber name*

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber

Allergies

INSERT ALLERGY INFORMATION

Side effects I have had:

INSERT SIDE EFFECT INFORMATION

Other information:

OPTIONAL

My notes and questions: