MY MEDICATION LIST

Name _____ Date of Birth_____

Doctor _____ Phone _____

Pharmacy _____ Phone _____

Allergies _____

_____

List all prescriptions, over-the-counter medicines, vitamins, herbal and dietary supplements.

Medication Name **Date Started**	**Dose** (mg, drops, etc.)	**When Taken** (daily, morning, at night, etc)	**Reason for Taking** (Blood pressure, diabetes, etc)

You can help make your health care safer by keeping this list current. Complete this form and keep it with you at all times. Bring this form with you to any visit to a hospital, healthcare provider, pharmacist or doctor. Visit Carteret Health Care's Web site at www.carterethealth.org for more information.