Medication List

Patient Name: _____ **Date Updated:** _____

Primary Care Provider:

Preferred Pharmacy: _____

Emergency Contact: _____

Prescription Medications

Medication	Strength	How Often	Why I Take It	Prescribing Provider

Injectable Medications

(Examples: insulin, injectable medications, biologics, vitamin B12 injections)

Medication	Dose	How Often	Why I Take It

Inhalers, Eye Drops & Other Medical Devices

(Examples: inhalers, nebulizers, eye drops, nasal sprays, medicated patches)

Medication/Device	How Often	Why I Use It

Over-the-Counter Medications

(Pain relievers, allergy medicine, antacids, etc.)

Vitamins & Supplements

Allergies

☐ Medications ☐ Foods ☐ latex ☐ Adhesives ☐ Other ☐ Other

Details: _____

Details: _____

Notes

_____

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Be sure to carry this list with you! I suggest keeping a dedicated notebook you can put in your purse or pocket.

Medication	Strength	How Often	Why I Take It	Prescribing Provider