My Medication List

My Name:

My Birth Date:

My Phone #:

My Email:

Preferred Pharmacy:

Phone #:

Address:

My Allergies:

MEDICATION Brand/generic name. Include Over the Counter medications and Vitamins	**DOSAGE**	**HOW MANY?**	**HOW OFTEN?**	**WHEN IS IT TAKEN?**	**REASON FOR TAKING?**	**WHO PRESCRIBED THIS MEDICATION?**
Example: Tylenol	*325 mg*	*2 tablets*	*Twice a day*	*9 am and 9 pm*	*headache*	*Dr Disney*

MEDICATION Brand/generic name. Include Over the Counter medications and Vitamins	**DOSAGE**	**HOW MANY?**	**HOW OFTEN?**	**WHEN TAKEN?**	**REASON FOR TAKING?**	**WHO PRESCRIBED THIS MEDICATION?**
Example: Ambien	*5 mg*	*1 tablets*	*daily*	*bedtime*	*sleep*	*Dr Disney*