

PERSONAL INFORMATION

My Medicine List

DATE FORM STARTED: /

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|--|--------------------|
| Name: | Primary Doctor: |
| Phone Number: | Other Doctor(s): |
| Birth Date: | Primary Pharmacy: |
| Emergency Contact (name/phone number): | Other Pharmacy(s): |

LIST ALLERGIES AND ANY OVER-THE-COUNTER, HERBAL MEDICINES, AND VITAMINS YOU TAKE.

| Alle | rgies to Medicine | | he-Counter Medicines amples: aspirin, antacids) | Herbal Medicines and Vitamins (examples: ginseng, ginko, Echinacea) | | | |
|--------------|----------------------------|-------|--|--|---------------------|--|--|
| Allergic to: | Describe allergicreaction: | Name: | Dose and Frequency: | Name: | Dose and Frequency: | | |
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LIST ALL PRESCRIPTION MEDICINES YOU CURRENTLY TAKE

| Date Started | Name of Medicine | Dosage (mg, ml) | Directions for taking (quantity, how often) | What time of day do you take the medicine? | | | Why are you taking this medicine? | Date stopped or changed | | Name of doctor who ordered the medicine | |
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