Medication List

Patient Name: _____ DOB: _____

Date List Started: _____ Page: _____ of _____

Pharmacy Name _____ Phone: _____

A Current Medication List Helps Prevent Errors.

RX Date	Medication Name & Strength To include over the counter meds such as vitamins, herbs, diet supplements	Dosage (mg, ml, etc)	How & When to Use (Daily, at bedtime, etc)	Stop Date

ALWAYS KEEP THIS FORM WITH YOU – Take it with you to all healthcare visits.
USE THIS FORM TO DOCUMENT ALL CHANGES MADE TO YOUR MEDICATIONS – Taking an active role in your healthcare can help prevent medication errors and **KEEP YOU SAFE!**