My Medication List

Name: _____ Birthday: _____

This list was last updated on (date): _____

Pharmacy name/location: _____

Medication allergies: _____

Medication Name	Strength (mg)	How many times per day?	Morning	Afternoon	Night	As Needed
Example medication	*100mg*	*Twice a day and as needed*	*x*		*x*	*x*

Did you remember the over-the-counter medications you take? Vitamins? Supplements?
Do you use any inhalers? Nasal sprays? Patches? Creams?
Do you use insulin? What kind(s) and what is your regimen?
Do you have any kind of medication pump or device (ex. Insulin pump, intrathecal pain pump)?