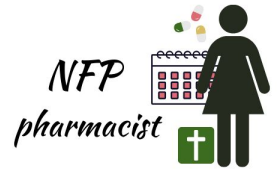


# My Medication List

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
<i>Example medication</i>	<i>100mg</i>	<i>Twice a day and as needed</i>	<i>x</i>		<i>x</i>	<i>x</i>

- 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)?