Medication List

Name: ____

Date of Birth: ____

Preferred Pharmacy: ____

Include prescription medicines, over-the-counter, vitamins and herbal remedies.
The accuracy of the medications is dependent on the information you provide.
Carry this list with you. Share it with your pharmacist and doctors.

Check here if not on any medications ☐					
Medication	**Dose**	**Frequency**	**Reason**	**Start Date**	**Stop Date**

Allergies:

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Doctors:

Name: ______________________________ Phone: ______________________

Name: ______________________________ Phone: ______________________