APPENDIX B: MEDICATION LIST TEMPLATE

Keep this list updated and bring it to all doctor visits.

MEDICATION LIST

Patient Name: _____

Date of Birth: _____

Date of this list: _____

ALLERGIES:

Medication allergies: _____

_____

Food allergies: _____

Other allergies: _____

CURRENT PRESCRIPTION MEDICATIONS:

1. Medication name: _____

Dose: _____ Frequency: _____

Route: ☐ By mouth ☐ Patch ☐ Injection ☐ Inhaler ☐ Eye/ear drops ☐ Other: _____

What it is for: _____

Prescribing doctor: _____

Pharmacy: _____

Date started: _____

Special instructions: _____

_____

_____

2. Medication name: _____

Dose: _____ Frequency: _____

Route: ☐ By mouth ☐ Patch ☐ Injection ☐ Inhaler ☐ Eye/ear drops ☐ Other: _____

What it is for: _____

Prescribing doctor: _____

Date started: _____

Special instructions: _____

_____

3. Medication name: _____

Dose: _____ Frequency: _____

Route: ☐ By mouth ☐ Patch ☐ Injection ☐ Inhaler ☐ Eye/ear drops ☐ Other: _____

What it is for: _____

Prescribing doctor: _____

Date started: _____

Special instructions: _____

_____

4. Medication name: _____

Dose: _____ Frequency: _____

Route: ☐ By mouth ☐ Patch ☐ Injection ☐ Inhaler ☐ Eye/ear drops ☐ Other: _____

What it is for: _____

Prescribing doctor: _____

Date started: _____

Special instructions: _____

_____

OVER-THE-COUNTER MEDICATIONS:

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

VITAMINS AND SUPPLEMENTS:

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

Name: _____

Dose/frequency: _____

Indications (What for): _____

AS-NEEDED (PRN) MEDICATIONS:

Medication name: _____

What it is for: _____

Dose/frequency: _____

When to use: _____

Medication name: _____

What it is for: _____

Dose/frequency: _____

When to use: _____

DISCONTINUED MEDICATIONS (and reason, if known):

Medication name: _____

Date stopped: _____ Reason: _____

PHARMACY INFORMATION:

Pharmacy name: _____

Phone: _____

Address: _____
