



APPENDIX B: Family Caregiver's MEDICATION LIST Form

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

MEDICATION LIST

Patient Name: _____ **Age:** _____

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:

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2. 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:

3. 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:

4. 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:

5. 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:



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): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____

Medication name: _____

Dose/frequency: _____

Indications (What for): _____



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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): _____

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: _____

Medication name: _____

Date stopped: _____

Reason: _____

Medication name: _____

Date stopped: _____

Reason: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Phone: _____

Address: _____

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Follow the Laws of Protected Health Information (PHI)

45 CFR 160.103

“Protected health information means individually identifiable health information transmitted or maintained in any form or medium.”