Personal Medicine List

Name _____ Date of Birth _____ Phone (___) _____

Vaccination Dates: Flu _____ Pneumonia _____ Tetanus _____ Other _____

Medicines I take, including those without a prescription: over-the-counter, vitamins, supplements, herbals, eye-drops, patches, etc.

Medicine Name & Strength Example: Senicidem 40 mg	How Much & When I Take It Example: 2 tablets twice a day with meals	What I Take It For Example: Blood Pressure	Other Information Example: Get Blood Work Monthly

Date I Last Updated My List: _____ _____ _____

Bring all of your medicines with you to every healthcare visit (hospital, doctor, clinic, etc.). Remember to bring non-prescription medicines as well as prescription medicines.