

# MEDICATION LIST

(Update, date, and give to all your doctors', dentists or other healthcare professionals. Keep one in a file at home and tell family where it is located.)

**Your Name (First & Last)** \_\_\_\_\_ **Date of this Report** \_\_\_\_\_

Name of Medication or Supplement	Strength (usually in mgs) <i>Be careful with decimal points!!!</i>	How much & how often <i>Ex. 2 tablets twice a day</i>	Prescribing Doctor, City & Telephone # (and/or doctor who told you to stop or change dose)	Date Started // Stopped
				Start: _____ Stop: _____
				Start: _____ Stop: _____
				Start: _____ Stop: _____
				Start: _____ Stop: _____
				Start: _____ Stop: _____
				Start: _____ Stop: _____
				Start: _____ Stop: _____

Allergies Name of Medication	Strength	Reaction You Experienced
<b>Negative Side Effects: Medication</b>		