My Medications

MyMedsList.org

CRITICAL PATH INSTITUTE
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My Name: _____ Date Completed: _____

Emergency Contact: _____ Phone: _____
(Insert Relative or Friend)

- **Write all prescriptions, over-the-counter medicines and supplements below**
- **Keep this list up-to-date and with you at all times**
- **Send and/ or show the list to your doctors and pharmacists at each visit**
- **Ask them to check for unnecessary duplications or medicines that could interact to cause harm**
- **This list will help you take medicines correctly**

Find more copies of this list at MyMedsList.org

Check below the types you use. Write the names of medicines in the chart

- ☐ Allergy Medicines
- ☐ Antacids
- ☐ Antibiotics
- ☐ Blood pressure or heart medicines
- ☐ Cold, flu or cough medicines
- ☐ Herbs and dietary supplements
- ☐ Hormones or contraceptives
- ☐ Laxatives
- ☐ Medicine patches or skin creams
- ☐ Pain medicines
- ☐ Sleeping pills
- ☐ Vitamins, minerals
- ☐ Weight loss pills

Name of Medicine or product	How much do I take at each dose?	When and how do I take it?	Why do I take it?	Date I started it	Date I stopped
Example: Naproxen	1 tablet, 250 mg	7AM and 7PM, with food	Arthritis	7/31/2009	N.A.

List all medicines you avoid due to allergies or side effects: _____

_____

Your Primary Doctor: _____ Phone: _____ Pharmacy: _____ Phone: _____