





Home Medications List

Bring this list with you to all medical appointments and hospital visits.

Name	Date of birth	Telephone number
Emergency contact	Relationship to me	Emergency contact telephone number
Pharmacy _____		Pharmacy telephone number _____
Pharmacy _____		Pharmacy telephone number _____
Allergies or problem with medications <small>*Add additional sheets as needed</small>		
Name of medication _____		What happens when I use it _____
Name of medication _____		What happens when I use it _____
Name of medication _____		What happens when I use it _____

In the boxes below, write any medications, medicated creams/ointments, vitamins, supplements and/or CBD (cannabidiol) products you are currently taking/applying.

Medication name/strength/ dose (Example: Metoprolol 25MG 1 tablet; Tylenol 500 MG, 1 tablet)	When I take it				What day(s) I take it (Example: Daily / M, W, F / Only as needed)	Why I take it (Example: Blood pressure)	Who ordered it (Example: Prescribed or recommended by Dr. Smith or non- prescription given by self)
	Morning 	Midday 	Evening 	Bedtime 			

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