MY MEDICATIONS

Name:	**Date:**
Date of Birth:	
Medication Allergies:	
Completed by: ☐ **Patient** ☐ **Family/Significant Other** ☐ **Nurse** ☐ **Friend**	

CURRENT MEDICATIONS:

1) Medications prescribed to me by my doctor

Medication	Dosage	How often do you take this?

2) Over-the-counter medications I take (ex. aspirin, Tylenol, vitamins, antacids, etc.):

Medication	Dosage	How often do you take this?

3) Herbal medications I take (ex. Staint-John's-wort, ginkgo biloba, ginseng, Zing, etc.)

Medication	Dosage	How often do you take this?