OUR TERMINAL

Medication List

USE THIS AS A RESOURCE TO CHART ALL MEDICATIONS

My Medication List

BE SURE TO INCLUDE ALL PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICINES, VITAMINS, DIETARY SUPPLEMENTS, HERBS, HOMEOPATHIC REMEDIES, OXYGEN, AND INHALERS.

Name: _____

Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

MEDICATION NAME/DATE STARTED	DOSAGE (MG, UNITS, DROPS)	WHEN TAKEN (DAILY, BEDTIME, ETC)	REASON FOR TAKING (BLOOD PRESSURE, DIABETES, ETC)