# Medication List

## Information:

| | |
|---|---|
| **Name:** | **Address:** |
| **Phone number:** | |
| **Date of Birth:** | |
| **Emergency Contact/phone:** | |

## Allergies

| | |
|---|---|
| Allergic to: | Reaction: |
| Allergic to: | Reaction: |
| Allergic to: | Reaction: |

List ALL medications you are currently taking: please include prescriptions, over-the-counter medications, and herbals. *Update with each visit to your provider.*

| Drug Name | Directions: How I take this | I started taking this on: | I stopped taking this on: | Why I take this medication | Doctor's name |
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