MY MEDICINE LIST, continued

Keep this page with other pages of this form in your wallet or purse

NAME: ______________________________

Allergies to Medicine		Over-the-Counter Medicines (examples: aspirin, antacids)		Herbal Medicines and Vitamins (examples: ginseng, gingko, echinacea)	
Allergic to:	Describe allergic reaction:	Name:	Dose and frequency:	Name:	Dose and frequency:

Date started	Name of Medicine	Directions for taking (dose, how often)	What time of day do you take the medicine?					Why are you taking this medicine?	Date stopped or changed		Name of doctor who ordered the medicine
			MORNING	NOON	SUPPER	BEDTIME	AS NEEDED		STOPPED	CHANGED	

Additional forms and additional pages for this form are available at www.mocps.org or by calling 1-800-735-6776