Document Created on: _____By:_____

Medication List

Name: _____Date of Birth: _____

Primary Care Provider: _____ Preferred Pharmacy: _____

Medication Allergies: _____

Current Medications

Medication	Strength/Dose	How Often?	Why Do I Take It?

Vitamins & Supplements

Name	Dose

Helpful Tips

- Update this list whenever a medication is started, stopped, or changed.
- Bring this list to every medical appointment.
- Keep a copy in your wallet, purse, or emergency folder.
- Consider sharing a copy with a trusted family member or healthcare proxy.