Medication List for: _____ DOB: _____
(member name)

Medication List

Prepared on: _____
(date of Comprehensive Medication Review)

Bring your Medication List when you go to the doctor, hospital, or emergency room. And, share it with your family or caregivers.

Note any changes to how you take your medications.
Cross out medications when you no longer use them.

Medication	**How I take it**	**Why I use it**	**Prescriber**
(Insert generic name and brand name, strength, and dosage form for current/active medications)	*(Insert regimen, (e.g., 1 tablet by mouth daily), use of related devices, and supplemental instructions as appropriate)*	*(Insert indication or intended medical use)*	*(Insert prescriber name)*

Medication List for: _____ DOB: _____
(member name)

Add new medications, over-the-counter drugs, herbals, vitamins, or minerals in the blank rows below.

Medication	How I take it	Why I use it	Prescriber

Allergies:
(insert any allergy information)

Side effects I have had:
(insert any side effect information)

Other information:
(optional)

My notes and questions: