Personal Medication List

Patient Name:_____ **Patient DOB:**_____ **Primary Dr:**_____

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) per Day	Form (liquid, capsule, tablet)	Special Directions

Over-the-Counter Medications	Purpose or Reason Taken	Dose	Time(s) per Day	Form (liquid, capsule, tablet)	Special Directions

Drug Allergies and Reaction:		
Local Pharmacy:	**Address:**	**Phone:**
Mail Order Pharmacy	**Address:**	**Phone:**