



**MY LIST OF MEDICATIONS & DRUG ALLERGIES**

**Medical Record #:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

**Pharmacy Address or Crossroads:** \_\_\_\_\_

**Current Medications:** This list includes all prescribed medications, over-the-counter medications, vitamins and other supplements (herbal or non-traditional).

Medication Name	Dose (i.e. 100 mg)	Times / Day	Date Updated	Medication is Taken (oral, injections, topical, etc.)

**Drug Allergies:** This list includes all known drug allergies and type of reaction.

No known drug allergies.

Medication Name	Type of Reaction

Medication Name	Type of Reaction