The medications you take are a very important part of your health information. Please fill out this medication list (or have your caregiver complete it) and discuss it with your medical provider. Also, bring this list with you to doctor appointments and when you go to the hospital. If you need more space to list your medications, copy this form or use a blank piece of paper.

PATIENT NAME: _____ PRIMARY CARE DOCTOR: _____

ALLERGY (drug name or food)	Type of reaction (e.g., rash)

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If a medication is stopped, draw a single line through it and write in the date the medication was stopped

PRESCRIPTION DRUG NAME (e.g., Atenolol) Date		**STRENGTH** (e.g., 50 mg)	**DIRECTIONS** (e.g., 1 tablet each AM)	**PRESCRIBING DOCTOR** (e.g., Dr. John Doe)	**REASON FOR MEDICATION** (e.g., blood pressure)	**DATE MEDICATION STOPPED**

OVER THE COUNTER MEDICATIONS (e.g., Aspirin)	**STRENGTH** (e.g., 325 mg)	**DIRECTIONS** (e.g., 1 tablet daily)	**PRESCRIBING DOCTOR – if prescribed**	**REASON FOR MEDICATION** (e.g., prevent heart attack)	**DATE MEDICATION STOPPED**

HERBALS, VITAMINS, MINERALS, ETC. (e.g., St. John's Wort)	**STRENGTH** (e.g., 300 mg)	**DIRECTIONS** (e.g., 1 capsule daily)	**PRESCRIBING PROVIDER – if prescribed**	**REASON FOR MEDICATION** (e.g., depression)	**DATE MEDICATION STOPPED**

Pharmacy Name and Phone Number:_____

Immunization and Vaccines	
Last Pneumonia Vaccine (Pneumovax):	Last Tetanus Immunization:
Last Flu Shot (influenza vaccine):	Other:

EVERGREEN HEALTHCARE

PATIENT CURRENT MEDICATION LIST

Form ID RX 320

Approved: 11/07

APPLY PATIENT LABEL HERE

Original – Medical Record Photocopy – Patient