For Your Safety…

Home Personal Medication Form

Name: ____________________________ Date of Birth: __________________Allergies: __________________________________

Medications Please list all prescriptions and non-prescription medications, herbals, nutritional supplements, eye drops, inhalers, etc. that you use. (Cross out medicine name if no longer taking)

* **Remember**, it is important to keep this information up to date.

Name of Medicine (exactly as on pill bottle)	**Dose** (mg, mcg, unit, puffs, drops)	**Route** (by mouth, topical, eye drops)	**Directions** (How often do you take this med?)	**Ordering Doctor**

Primary Physician: ___________________

Phone: ( ) ______-________________

Preferred Pharmacy: _______________________

Phone: ( ) ______-________________