Medicine ordered by your doctor

Start Date	Name of Medicine	Dose (units, puffs, drops)	When do you take it? How many times per day, morning and night?	Purpose (Why you take it?)	Comments

Medical Conditions: ❑ Asthma ❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ Other _____

Known Drug/Food Allergies:_____

28547DM1112

My Medicine List

Name: _____

Date: _____

My Doctor:

_____

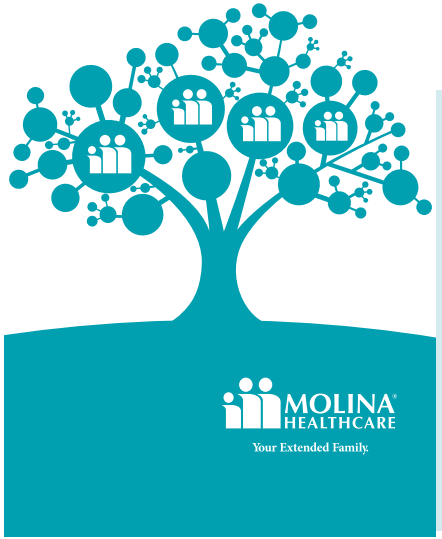
Phone:_____

My Pharmacy:

_____

Phone:_____

My Medicine



It is often helpful to keep a list of all your medicines. We hope this card can be useful and can be carried in your wallet.

Fill in all the medicines you are taking. Review this card as your medicines change.

Over-the-Counter Medicines

Check if you are using any of these:

- ❑ Allergy relief
- ❑ Aspirin/other pain medicine
- ❑ Diet pills
- ❑ Vitamins/Minerals
- ❑ Antacid
- ❑ Cough/cold medicine
- ❑ Laxatives
- ❑ Sleeping pills
- ❑ Herbs (please list name)_____
- ❑ Other (please list name)_____