Personal Medication List

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions
Over-the-Counter Medications	**Purpose or Reason Taken**	**Dose**	**Time(s) of Day**	**Form (Liquid, capsule, tablet)**	**Special Instructions**

Health Problems _____

Primary Doctor _____ **Doctor's Phone** _____

Local Pharmacy _____ **Pharmacy Phone** _____

Drug Allergies _____ **Your Phone** _____

Your Name _____ **Date** _____

Adapted by the American Society of Consultant Pharmacists (ASCP) Foundation
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