

## **MY LIST OF MEDICATIONS & DRUG ALLERGIES**

	Medical Record #:				
Patient Name: D					Date:
Preferred Pharmacy:	·				
Pharmacy Address of	or Crossroads:				
Current Medications					ver-the-counter (herbal or non-
Medication Name	Dose (i.e. 100 mg)	Time	es / Day	Date Updated	Medication is Taken (oral, injections, topical, etc.)
Drug Allergies: This	s list includes al	l known	drug allerg	ies and type of	reaction.
No known drug a	allergies.				
Medication Name	Type of Reaction		Medic	cation Name	Type of Reaction