Patient Home Medication List

Why do I need to fill out this form?
We need a written list of all your medications and how you take them so your healthcare team can properly care for you during and following your hospital stay.

What can I do if I do not have this information with me?
Call a family member or friend to bring your medications to you.

Call your pharmacy for a list of your medications.

Discuss your medications with your nurse or doctor.

If I come to the hospital, what should I bring?

- This medication list
- Your medications
- Insurance Card
- Health Care Proxy/MOLST

What do I need to include?
Include all the medications you take such as pills, inhalers, eye drops, patches, injections, creams, and so on.

Also include the medications you buy over the counter such as vitamins, eye drops, creams, herbal supplements, patches, inhalers, Insulin, etc.

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PATIENT HOME MEDICATION LIST

Always keep this form with you. Please give a copy to your emergency contact. Update this list when medications change.
Include ALL prescription drugs, over-the-counter medications, vitamins, eye drops, creams, herbal supplements, patches, inhalers, Insulin, etc.

	Medication Name (Copy name directly from bottle)	**Dosage** (2mg, 1 tsp, 2 drops, etc.)	**How Often** (Daily, Nightly, as needed, etc.)	**Time of Day taken**	**Reason** (Why you are taking)	**Prescribing MD** (Prescriber)	**Currently Taking?**
	(EXAMPLE) Ibuprofen	*400 mg*	*2x a day*	*1 p.m.*	*Mild pain*	*Doctor's name*	☐ Yes ☐ No
1							☐ Yes ☐ No
2							☐ Yes ☐ No
3							☐ Yes ☐ No
4							☐ Yes ☐ No
5							☐ Yes ☐ No
6							☐ Yes ☐ No
7							☐ Yes ☐ No
8							☐ Yes ☐ No
9							☐ Yes ☐ No
10							☐ Yes ☐ No
11							☐ Yes ☐ No
12							☐ Yes ☐ No

If more space is needed, please print additional pages

Allergy: _____/Reaction: _____ Allergy: _____/Reaction: _____

Allergy: _____/Reaction: _____ Allergy: _____/Reaction: _____

Pneumonia shot date: _____ Flu shot date: _____

Emergency Contact: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy you use: _____ Phone: _____ Pharmacy you use: _____ Phone: _____

Patient Printed Name: _____