

## MY MEDICINE LIST

Fold this form and keep it with you

For copies of  
My Medicine List  
visit the Minnesota Alliance  
for Patient Safety's website at  
[www.mnpatientsafety.org](http://www.mnpatientsafety.org)



Name:	Date of Birth:
<b>Allergic To:</b> <i>(Describe reaction)</i>	
Emergency Contact/Phone numbers:	
Doctor(s):	
Pharmacies, other sources:	

### Immunization Record

*(Record the date/year of last dose taken)*

Flu vaccine(s):

Pneumonia vaccine:

Tetanus:

Hepatitis vaccine:

Other:

1. ALWAYS KEEP THIS FORM WITH YOU—preferably in your wallet or purse. If appropriate, consider sharing your information with adult children.
2. Write down all of the medicines (prescriptions and over-the-counter drugs) you are taking, and list all of your allergies.
3. Take this form with every time you go to your clinic, pharmacy, hospital, physician, or other providers.
4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES. If you stop taking a medicine, cross it off the list. If you add another medicine, put it on the list.

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING ON THE BACK OF THIS FORM**

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**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING ON THE BACK OF THIS FORM**

**List all medicines you are currently taking.** Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids, vitamins) and herbals (examples: ginseng, ginkgo). Include medications taken as needed (example: nitroglycerin, inhalers).

<b>START DATE</b>	<b>NAME OF MEDICATION</b>	<b>DOSE</b>	<b>DIRECTIONS</b> <i>(How do you take it? When? How often?)</i>	<b>DATE STOPPED</b>	<b>NOTES</b> <i>(reason for taking?)</i>

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