*Please include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other important illnesses.

Name of Medication	Prescribed By	Dosage mg/ units/ puffs/ drops	When is the Medication Taken How many times per day? Morning and/or night? After meals?	Purpose	Refills needed
Medication ABC	*Dr. ABC*	*5 mg*	*2 times, morning and night*	*Ulcer*	*yes*

Please list all the medications you are taking, including over-the-counter medications, vitamins, herbs, and other treatments. Include the name of the doctor who prescribed the medications, and why you are taking the medications (e.g. for high blood pressure, arthritis, cholesterol, etc.) If you are not sure why you are taking the medication, write "don't know", and ask your doctor to explain why and how to use the drug properly. Also ask about the drug's side effects and what to do if you experience a side effect.

Remember to update your medicine list when your doctor stops, changes, or updates your medications. Please bring your medication list with you to doctors' visits, emergency room or walk in clinic visits, nursing home visits, to your home health providers, and to the hospital. If you are unable to bring a medication list with you to your doctor's appointment, please bring your bottles.