My Medication List

Name: _____

Last Updated: _____

Please bring this completed list to all appointments

ByWard
ÉQUIPE DE SANTÉ FAMILIALE
FAMILY HEALTH TEAM

Medication Name (list all prescription and non-prescription medications, natural products, vitamins and over-the-counter products)	**Strength** (e.g., mg, units, etc.)	**How do I take the medication?** (e.g., 1 tablet by mouth twice a day)	**What time of day do I take this medication?**					**Why am I taking this medication?**	**Who prescribed this medication?**
			Morning	**Noon**	**Dinner**	**Bedtime**	**As needed**		

Medication Name	Strength	How do I take the medication?	Morning	Noon	Dinner	Bedtime	As needed	Why am I taking this medication?	Who prescribed this medication?