Health Sciences North
Horizon Santé-Nord

MY MEDICATION LIST

DATE FORM UPDATED: _____ _____ _____ _____ _____

Name:	**Family Doctor/Nurse Practitioner:**	**Phone:**
Birth Date:	**Other Doctor(s):**	**Phone:**
Home Phone Number:	**Regular Pharmacy:**	**Phone:**
Emergency Contact Name and Number:	**Other Pharmacy(s):**	**Phone:**

List All Allergies (Medication or Food)

Allergic To:	**Describe Reaction:**	**Allergic To:**	**Describe Reaction:**

List All Prescription Medications, Over-The-Counter Medicines, Herbal Supplements or Vitamins You Take (continue on second page if needed)

Date Started	**Name of Medicine and strength (e.g. mg/units)**	**How do you take the medication (e.g. take 1 tablet by mouth 2 times a day)**	**What time of day do you take the medicine?**					**Why are you taking this medicine? (or comments)**
			Morning	Noon	Dinner	Bedtime	As needed	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	

Date Started	Name of Medicine and strength (e.g. mg/units)	How do you take the medication? (e.g. take 1 tablet by mouth 2 times a day)	What time of day do you take the medicine?					Why are you taking this medicine? (or comments)
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			☐	☐	☐	☐	☐	
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NAME:____