MY MEDICINE LIST, continued

Keep this page with other pages of this form in your wallet or purse

NAME: _____

Allergies to Medicine Allergic to: Describe allergic reaction:	**Over-the-Counter Medicines** (examples: aspirin, antacids) Name: Dose and frequency:	**Herbal Medicines and Vitamins** (examples: ginseng, gingko, echinacea) Name: Dose and frequency:

Date started	**Name of Medicine**	**Directions for taking (dose, how often)**	**What time of day do you take the medicine?**					**Why are you taking this medicine?**	**Date stopped or changed**		**Name of doctor who ordered the medicine**
			MORNING	**NOON**	**SUPPER**	**BEDTIME**	**AS NEEDED**		**STOPPED**	**CHANGED**	

Additional forms and additional pages for this form are available at www.mocps.org or by calling 1-800-735-6776

Missouri Center for Patient Safety