Medication List Template

Every medicine, strength and reason on one page you can hand over.



WHY IT HELPS

Every nurse, pharmacist and doctor asks what you take. Answering from memory when you are tired, sick or in a hurry is when names and doses slip. One written list answers for you, even when you cannot.

HOW TO USE IT

List	Copy each medicine from its label.
Check	Go over it with your pharmacist.
Carry	Cut out the wallet card, update the list after every change.

INSIDE

1	The cover	2	A filled-in example
3	My medication list	4	Supplements and as-needed
5	My day at a glance	6	Allergies, contacts, wallet card
7	Changes and next appointment		

Copy names and strengths straight from the label. Write the brand and generic name when both are printed.

NAME
Ruth Miller

DATE OF BIRTH
04/12/1955

UPDATED ON
March 18

ALLERGIES AND REACTIONS
Codeine: vomiting (2015). Latex: itchy rash.

1 Prescription medicines

One row per medicine, copied from the label

MEDICINE	STRENGTH	HOW MUCH AND WHEN	WHAT IT IS FOR	STARTED	PRESCRIBED BY
Amlodipine	5 mg	1 tablet every morning	Blood pressure	2019	Dr. Patel
Metformin ER	750 mg	1 tablet with dinner	Blood sugar	2021	Dr. Patel
Rosuvastatin	10 mg	1 tablet at bedtime	Cholesterol	2020	Dr. Patel
Omeprazole	20 mg	1 capsule before breakfast	Heartburn	2023	Dr. Okafor
Vitamin B12 shot	1,000 mcg/mL	1 mL once a month at the clinic	Low B12	2022	Dr. Okafor

2 Supplements and as-needed medicines

NAME	STRENGTH	WHEN I TAKE IT	WHAT IT IS FOR
Calcium citrate	600 mg	With lunch	Bone health
Loratadine	10 mg	Only on high pollen days	Hay fever
Artificial tears		1 drop in each eye, when dry	Dry eyes

3 My day at a glance

Morning	Midday	Evening	Bedtime
Amlodipine 5 mg	Calcium citrate 600 mg	Metformin ER 750 mg	Rosuvastatin 10 mg
Omeprazole 20 mg			

NAME

DATE OF BIRTH

UPDATED ON

ALLERGIES AND REACTIONS

1 Prescription medicines

One row per medicine, copied from the label

MEDICINE	STRENGTH	HOW MUCH AND WHEN	WHAT IT IS FOR	STARTED	PRESCRIBED BY

1 Vitamins, minerals and herbal products

NAME	STRENGTH	WHEN I TAKE IT	WHAT IT IS FOR	SINCE

2 Medicines I take only when needed

Pain, allergy, sleep or stomach medicines

NAME	STRENGTH	WHAT I TAKE IT FOR	MOST I TAKE IN A DAY (LABEL OR PHARMACIST)

3 Inhalers, creams, drops, patches and injections

NAME	STRENGTH	HOW AND WHEN	WHAT IT IS FOR

1 My day at a glance

Write each medicine under the time you take it

Morning	Midday	Evening	Bedtime

2 Medicines on set days only

For example weekly or monthly

MEDICINE	WHICH DAYS	TIME OF DAY

3 Reviewed with

Go over the whole list once a year or after any change

DATE	PHARMACIST OR DOCTOR	WHAT WE CHECKED OR CHANGED

1 Allergies and reactions

Write No known drug allergies if you have none

MEDICINE, FOOD OR MATERIAL	WHAT HAPPENED	YEAR

2 My care team

ROLE	NAME	PHONE
Pharmacy		
Main doctor		
Specialist		
Specialist		
Other		
Emergency contact		
Poison Help (US)		1-800-222-1222

3 Wallet card

Cut along the dashed line and fold in half.

NAME

DATE OF BIRTH

ALLERGIES

EMERGENCY CONTACT AND PHONE

KEY MEDICINES AND STRENGTHS

CONDITIONS

PHARMACY AND PHONE

1 Medicine changes

Started, stopped, new dose or new time

DATE	MEDICINE	CHANGE	WHO CHANGED IT	WHY

FOR MY NEXT APPOINTMENT

What I want to raise with my doctor or care team.

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