My Medicines List

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| --- | --- | --- |
| My Name:  | My Allergies:  | My Emergency Contact Information: |
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| --- |
| Date: |

**My medicines, vitamins, herbals, and supplements, as of**

Include all **prescription** and **non-prescription** medicines. Non-prescription medicines may include vitamins, herbals, supplements, cold or cough medicines, aspirin, pain relievers, allergy relief medicines, antacids, laxatives, diet pills, and others that you do not need a prescription to buy.

| **I take these every day** |
| --- |
| **Name (brand and generic)** | **Strength of medicine** | **I take this medicine for** | **When, how, and how much I take** |
| **Instructions** | **Morning** | **Noon** | **Evening** | **Bedtime** |
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| **I take these regularly, but not every day** |
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| **Name (brand and generic)** | **Strength of medicine** | **I take this medicine for** | **When, how, and how much I take** |
| **Instructions**  | **When** |
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| **I take these only when I need them** |
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| **Name (brand and generic)** | **Strength of medicine** | **I take this medicine for** | **When, how, and how much I take** |
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