Medication List

In order to provide the safest care for you, please complete the following form. Bring this medication list with you anytime you come to the hospital. Please let us know of any changes to this list at the time of your admission to the hospital.

For your safety you will be asked several times for your current list of medications. Completing this form will allow you to quickly and accurately recall your medications when asked.

Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

Allergies (Medication, Food, Latex)

Name	Describe Reaction

Medication (Prescription, over-the-counter, vitamins, herbal supplements)

Name	Dosage	Frequency	Reason for taking	Date Started

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ST. JOSEPH
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