My Medicine List



NAME:		

- Please list all medicine(s) you take. Include drugs, herbs, vitamins, and supplements.
- Bring this list to every doctor, urgent care, or hospital visit, and to the pharmacy.
- Don't run out of medicine. Talk to your doctor and pharmacy when you need more.
- Ask your doctor or pharmacy if you have any questions or concerns about your medicines.

	e This Medicine is for my:	When do I take it? How much? How often?				Start	Stop
Medicine Name and Dose		Morning	Noon	Evening	Bedtime	Date:	Date:
EXAMPLE: Hydrochlorothiazide 25 mg	High blood pressure	1 white pill (every day)				1/1/24	NONE

My Medicine List

	This Medicine is for my:	When do I take it? How much? How often?				Start	Stop
Medicine Name and Dose		Morning	Noon	Evening	Bedtime	Date:	Date:

Adapted from My Medication List – Keep it Handy, New York City Department of Health and Mental Hygiene.

DOCTOR'S NAME:	PREFERRED PHARMACY:	PREFERRED PHARMACY:			
PHONE NUMBER:	PHONE NUMBER:				



Questions? Please call Alliance Health Programs • Monday – Friday, 8 am – 5 pm

Phone Number: **1.510.747.4577** • Toll-Free: **1.877.932.2738**

People with hearing and speaking impairments (CRS/TTY): 711/1.800.735.2929

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