SAINT BARNABAS HEALTH CARE SYSTEM
New Jersey's Health Care Leader

My Medication List

Keep this medication list in your wallet or purse.
Share it with your doctors, pharmacist and other health care professionals at ALL visits

Personal Information		**Allergies to Medicine**	
Name:		**Allergic To**	**Describe Reaction**
Address:			
Birth Date:			
Primary Care Physician	**Name:**	**Phone #:**	

List all medicine you are currently taking: Prescription and over-the–counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Prescription Medication Name	**Dose (How much)**	**Frequency (How often)**

Over-the-Counter Medications/Vitamins/Herbals		
Name of Medication	**Dose (How much)**	**Frequency (How often)**

Medication List Completed or Updated (Date): _____ **Page** _____ **of** _____