My Medications and Supplements List

My Name is: _____ My Date of Birth: _____

Medication Name For Prescriptions and Over The Counter (As listed on the bottle)	**Strength** (As listed on the bottle)	**How I take It** (by mouth, pill or liquid, cream, drops, injection)	**How Often I Take it** (Once/twice/3 times a day, As needed, etc.)	**My Pharmacy for this Medication**	**My Pharmacy is Located At**:

Supplements (Vitamins, Herbal Products)	**Strength** (As listed on the bottle)	**How I take It** (by mouth, pill or liquid, cream, drops)	**How Often I Take it** (Once/twice/3 times a day, As needed, etc.)	**Why I take a Supplement or Herbal Product**