Penobscot Valley Hospital

Name_____ Date of Birth_____ Pharmacy_____

Medication List

Allergies_____ Your Doctor's Name:_____

Please bring this sheet to all medical appointments and share it with your healthcare providers. ***This will help keep you safe and ensure you get the best care.***

Name of the Medication	Medication Other name	Dose (Strength)	Directions on how often to take the medication	Why are you taking it?	Comments or Changes	

***Medication Names:** sometimes medications have more than one name, such as Advil & Ibuprofen. If you know of any additional names, please list them.*

***Comments or Changes:** please use this section to list problems or reactions to medication, when you stopped or restarted taking the medication, etc.*