

Pharmacy Name
Address
City, St Zip



PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

This medication list was made for you after we talked. We also used information from your prescription claims data.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers to update this list at every visit.

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

Keep this list up-to-date with:

- prescription medications
- over the counter drugs
- herbals
- vitamins
- minerals

DATE PREPARED: XX/XX/XXXX

Allergies or side effects:
SAMPLE

Medication: SAMPLE

How I use it: SAMPLE

Why I use it: SAMPLE

Prescriber: SAMPLE

Notes:

Date I started using it:

Date I stopped using it:

Why I stopped using it:

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

(Continued)

Medication: SAMPLE

How I use it: SAMPLE

Why I use it: SAMPLE

Prescriber: SAMPLE

Notes:

Date I started using it:

Date I stopped using it:

Why I stopped using it:

Medication: SAMPLE

How I use it: SAMPLE

Why I use it: SAMPLE

Prescriber: SAMPLE

Notes:

Date I started using it:

Date I stopped using it:

Why I stopped using it:

Medication: SAMPLE

How I use it: SAMPLE

Why I use it: SAMPLE

Prescriber: SAMPLE

Notes:

Date I started using it:

Date I stopped using it:

Why I stopped using it:

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

(Continued)

Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	Prescriber:
Notes:	
Date I started using it:	Date I stopped using it:
Why I stopped using it:	

PERSONAL MEDICATION LIST FOR PATIENT NAME, DOB:XX/XX/XXXX

(Continued)

Other Information:

If you have any questions about your medication list, call <Pharmacist Name> at XXX-XXX-XXXX between the hours of <Pharmacist hours of availability>.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB number for this information collection is 0938-1154. The time required to complete this information collection is estimated to average 37.76 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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