Pharmacy Name
Address
City, St Zip

CareSource

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:	

(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>.

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