



Patient Home Medication List

Please give a copy to your emergency contact. Update this list when medications change. Include **ALL** prescription drugs, over-the-counter medications, vitamins, eye drops, creams, herbal supplements, patches, inhalers, insulin, etc.

Name: _____

D.O.B. _____

Allergies: _____

Pneumonia shot date: _____

Flu Shot Date: _____

Emergency Contact: _____

Phone #: _____

Primary Care Physician: _____

Cardiologist: _____

Insurance Provider _____

Pharmacy You Use: _____

Medication	Dosage	How Often	Reason

You can download a copy of this medication list on our web site: www.hshs.org/heart