Home Medication List

Date: _____

Allergies: Please list all allergies to medications, foods, x-ray dyes, iodine or other with reaction description. If no known allergies; check here ☐

Source	Reaction	Source	Reaction
1.		4.	
2.		5.	
3.		6.	

Instructions:
Please list ALL prescriptions **and** over-the-counter medications including eye drops, topical patches and injections. Please include vitamins and herbal products you are currently using.

☐ Not taking any medications at home

Name of Drug	Strength	# of tablets /capsules	Route	When is the Medication used or taken? (How many times per day? How often?)	Date started	Reason for using	Duration or Stop date?