



PERSONAL MEDICATION LIST FOR: <i>(name)</i> DOB: <i>(mm/dd/yyyy)</i>
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This medication list was made for you after we talked.

- 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 in your care team to update this list at every visit.

Keep this list up-to-date with:
<input type="checkbox"/> prescription medications
<input type="checkbox"/> over the counter drugs
<input type="checkbox"/> herbals
<input type="checkbox"/> vitamins
<input type="checkbox"/> minerals

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

DATE PREPARED:

Allergies or side effects:

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

PERSONAL MEDICATION LIST FOR: *(name)*

DOB: *(mm/dd/yyyy)*

(Continued)

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

PERSONAL MEDICATION LIST FOR: *(name)*

DOB: *(mm/dd/yyyy)*

(Continued)

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

PERSONAL MEDICATION LIST FOR: (name)

DOB: (mm/dd/yyyy)

(Continued)

Medication:**How I use it:****Why I use it:****Prescriber:****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:****Date I started using it:****Date I stopped using it:****Why I stopped using it:****Other Information:**

If you have any questions about your medication list, call our toll free number 218-327-6188 (voice), or 1-800-843-9536, 24 hours a day, 7 days a week. TTY users call 1-800-627-3529 or 7-1-1, or through the Minnesota Relay.

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