Hamilton Cardiology ASSOCIATES

My Medication List

Name _____

Doctor_____

Pharmacy_____

List all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication Name/Date Started	**Dose** (mg, units, drops)	**When Taken** (daily, at bedtime, etc.)	**Reason for Taking** (blood pressure, diabetes, etc.)