Partners
Obstetrics & Gynecology, PA
specialty care for women

My Medicine List

Please bring this **current** medication list to each appointment.

Name:	Date of Birth:	**Allergic To:** *(Describe reaction)*
Emergency Contact/Phone numbers:		
Doctor(s):		
Pharmacies, other sources:		

Immunization Record *(Record the date/year of last dose taken)*		Flu vaccine(s)	
Pneumonia vaccine:	Tetanus:	Hepatitis vaccine:	Other:

List all medicines you are currently taking. Include prescriptions (examples: pills, inhalers, creams, shots), over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: nitroglycerin, inhalers).

START DATE	NAME OF MEDICATION	DOSE	DIRECTIONS *(How do you take it? When? How often?)*	DATE STOPPED	NOTES *(Reason for taking?)*

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