Mills-Peninsula Health Services

A Sutter Health Af iliate

PATIENT LABEL

PATIENT'S HOME MEDICATION LIST

	What I'm taking*	Form (pill, injection, liquid, patch, etc.)	Dosage	How much and when	Use (regularly or as needed	Start/stop dates (e.g., 1/5 – 2/5 or 1/5 – ongoing)	Notes, directions, reason for use
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							

* Include ALL prescription drugs, over-the-counter medications, vitamins, eye drops, creams, and herbal supplements

Allergy	Reaction	Primary Care Physician:
		Physician's Phone #:
		Additional Comments:

Date _____ Patient Printed Name _____ Patient Signature _____

Lawson #307000 (3/11)
Medication-200073