Personal Medication Inventory For: _____

Prescription Medications I Take									
Medication Name	Dosage	How Often	To keep track of your daily medications, check the appropriate box in this section and record when (and how often) you've taken each prescription.						
			M	T	W	TH	F	S	S
Medications I am allergic to:									
Phone number of my pharmacy:									

Over-the-Counter Medications and Supplements I Take									
Medication or Supplement Name	Dosage	How Often	To keep track of your over-the-counter medications and supplements, check the appropriate box in this section and record when (and how often) you've taken each one.						
			M	T	W	TH	F	S	S
Medications I am allergic to:									
Phone number of my pharmacy:									

Wallet-Sized Personal Medication Inventory

Fill out this wallet-sized form, print it out, and fold it in half — it will fit neatly into your wallet. In the event of an emergency — or even if you're on vacation and lose your medication — you'll have all your prescription information handy.

Fold on this line ▼

Medication Inventory of:			Medications I am allergic to:
I Take the Following Prescription Medications:			
Name of Medication	**Dosage**	**How Often**	
			Pharmacy phone number:
			Emergency contact information
			Name:
			Relationship:
			Phone number(s):
			This form last updated on:

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