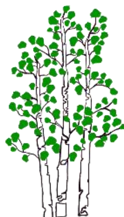

Fairbanks **CancerCare** Physicians P.C.

My Medication List

Name: ____ Date completed: ____________

Date of Birth:____

Height: __________________________________ Weight: ______________________________

Preferred Pharmacy: _________________________________ Phone: ____________________

Allergies: ____

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

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

You can help make your healthcare safer by keeping this list current. Complete this form and keep it with you at all times. Bring this form with you to any visit to a hospital, healthcare provider, pharmacist or doctor.

Pharmacy Benefit or Pharmacy RX Prescription card info:

Carrier: ______________________________________ Phone #: ________________________

Member Name: _________________________________ Member ID#: ____________________

RXBIN: ________________________________ RXPCN: _________________________________