Gulf Coast Medical Center
NCQA Recognized Patient-Centered Medical Home

My Medicine List

PLEASE KEEP A COPY OF THIS FORM IN YOUR WALLET

PERSONAL INFORMATION **DATE FORM STARTED:____ /____ /____**

Name:	Primary Doctor:
Phone Number:	Other Doctor(s):
Birth Date:	Primary Pharmacy:
Emergency Contact (name/phone number):	Other Pharmacy(s):

LIST ALLERGIES AND ANY OVER-THE-COUNTER, HERBAL MEDICINES, AND VITAMINS YOU TAKE.

Allergies to Medicine		**Over-the-Counter Medicines** (examples: aspirin, antacids)		**Herbal Medicines and Vitamins** (examples: ginseng, ginko, Echinacea)	
Allergic to:	Describe allergic reaction:	Name:	Dose and Frequency:	Name:	Dose and Frequency:

LIST ALL PRESCRIPTION MEDICINES YOU CURRENTLY TAKE

Date Started	Name of Medicine	Dosage (mg, ml)	Directions for taking (quantity, how often)	What time of day do you take the medicine?					Why are you taking this medicine?	Date stopped or changed		Name of doctor who ordered the medicine