



**PERSONAL MEDICATION LIST FOR \_\_\_\_\_ DOB: \_\_\_\_\_**

This medication list was made for you after we talked. We also used information from \_\_\_\_\_.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers in your care team to update this list at every visit.

Keep this list up-to-date with:

- prescription medications
- over the counter drugs
- herbals
- vitamins
- minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

**DATE PREPARED:** \_\_\_\_\_

**Allergies or side effects:** \_\_\_\_\_

|                                 |                                 |
|---------------------------------|---------------------------------|
| <b>Medication:</b>              |                                 |
| <b>How I use it:</b>            |                                 |
| <b>Why I use it:</b>            | <b>Prescriber:</b>              |
| <b>Date I started using it:</b> | <b>Date I stopped using it:</b> |
| <b>Why I stopped using it:</b>  |                                 |

**PERSONAL MEDICATION LIST FOR \_\_\_\_\_ DOB: \_\_\_\_\_**

(Continued)

|                                 |                                 |
|---------------------------------|---------------------------------|
| <b>Medication:</b>              |                                 |
| <b>How I use it:</b>            |                                 |
| <b>Why I use it:</b>            | <b>Prescriber:</b>              |
| <b>Date I started using it:</b> | <b>Date I stopped using it:</b> |
| <b>Why I stopped using it:</b>  |                                 |

|                                 |                                 |
|---------------------------------|---------------------------------|
| <b>Medication:</b>              |                                 |
| <b>How I use it:</b>            |                                 |
| <b>Why I use it:</b>            | <b>Prescriber:</b>              |
| <b>Date I started using it:</b> | <b>Date I stopped using it:</b> |
| <b>Why I stopped using it:</b>  |                                 |

|                                 |                                 |
|---------------------------------|---------------------------------|
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| <b>How I use it:</b>            |                                 |
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| <b>Date I started using it:</b> | <b>Date I stopped using it:</b> |
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**PERSONAL MEDICATION LIST FOR \_\_\_\_\_ DOB: \_\_\_\_\_**

(Continued)

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| <b>Date I started using it:</b> | <b>Date I stopped using it:</b> |
| <b>Why I stopped using it:</b>  |                                 |

|                           |
|---------------------------|
| <b>Other Information:</b> |
|---------------------------|

If you have any questions about your medication list, call ATRIO Health Plans customer service number at 1-877-672-8620 or, for TTY/TDD users, 1-800-735-2900, 8 a.m. to 8 p.m., Daily

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