**How to use the Medication List (MedList)**

It’s important to bring this **MedList** to all your healthcare visits. Having all your medications listed in one place helps your doctor, pharmacist, and other healthcare providers take better care of you. This **MedList** helps you keep track of what you’re taking to keep healthy, such as prescriptions, vitamins, over-the-counter medicine, herbs, and supplements.

To get a **MedList** for your phone or computer visit **www.albertahealthservices.ca/medlist**

If you need help filling out the **MedList**, ask your family, a friend, or a healthcare provider to help you.

1. Before filling in the list, gather all the medication you take (such as pills, patches, inhalers, eye/ear/nose drops, creams, ointments, and samples the doctor gave you). Be sure to include over-the-counter medicine, vitamins, minerals, herbal products, and recreational drugs (example: alcohol or marijuana).
2. Write down the following for each medication:
   1. The name (example: Tylenol®/acetaminophen).
   2. The dose or strength (example: 500 mg or 1000 Units).
   3. How much (example: 1 pill, 3 drops, or 2 puffs).
   4. How often and when (example: in the morning and/or evening. If it’s not listed, write how often or when in *Additional Information*).
   5. Why you take it (example: for arthritis).
   6. Additional information, such as take it with or without food, or who prescribed it (example: family doctor, specialist, naturopath).
   7. The date it was prescribed.

**Here’s an example:**

|  |  |  |  |  |  |  |  |  |  |  |
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| **Name of**  **Medication** | **Dose/**  **Strength** | **How Much** | **How Often and When**  Bedtime  As Needed  Afternoon  Evening  Morning | | | | | **Why I take it** | **Additional Information** | **Date** |
| *atorvastatin* | *20 mg* | *1 pill* |  |  |  | ✓ |  | *lower cholesterol* | *Dr. Goodheart* | *09-Jan-2015* |

1. Keep this list handy at all times, such as in your wallet or purse, so that you can share it with your healthcare provider when you have an appointment, test, or go to the hospital.

**Remember:**

* Update the **MedList** when there’s a change to your medication, such as stopping it, changing the dose, or starting a new one. Cross out the medication when you stop taking it, and write the date you stopped taking it.
* Speak with your doctor or pharmacist if you have questions about the medication you take.

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| First and Last Name | | | | | | | | Date of Birth | | Gender | | | | |
|  | | | | | | | |  | | Male | | Female | | |
| Personal Health Number | | Address | | | | | City | | Province | | Postal Code | | | |
|  | |  | | | | |  | |  | |  | | | |
| Emergency Contact Name | | | Phone | | | Secondary Emergency Contact Name | | | | | Phone | | | |
|  | | |  |  |  |  | | | | |  | |  |  |
| Family Doctor’s Name | | | Phone | | | Pharmacy Name | | | | | Phone | | | |
|  | | |  |  |  |  | | | | |  | |  |  |
| Specialist/Doctor’s Name | | | Phone | | | Specialist/Doctor’s Name | | | | | Phone | | | |
|  | | |  |  |  |  | | | | |  | |  |  |
| Benefits/Medical Plan Name and # (e.g. Alberta Blue Cross) | | | | | | | | | | | | | | |
| Medical History  Diabetes  High blood pressure  Heart conditions  Breathing problems | Other medical history: | | | | | | | | | | | | | |
| Allergies (The following is a list of **medications** I am **allergic** to, and what happens when I take them)  No medication allergies | | | | | | | | | | | | | | |

List all the medications you take, such as pills, patches, inhalers, eye/ear/nose drops, creams, ointments, and samples the doctor gave you. Be sure to include over-the-counter medicine, vitamins, minerals, herbal products, and recreational drugs (example: alcohol or marijuana).

**For your MedList to work, it’s important to keep it up to date: use the date column to indicate when old medications were stopped and new ones added!**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| This List belongs to | | | | | | | | Created on | | |
|  | | | | | | | |  | | |
| Name of Medication  *(example: atorvastatin)* | Dose/  Strength  *(20 mg)* | How Much  *(1 pill)* | How Often/When | | | | | Why I take it  *(to lower cholesterol)* | Additional Information  (take with or without food;  Prescribed by Dr. Goodheart) | Date  *(started or stopped)* |
|  |  |  | Morning | Afternoon | Evening | Bedtime | As Needed |  |  |  |
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| Morning | Afternoon | Evening | Bedtime | As Needed |
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