Billings Clinic℠

# My Medications

**Name:** _____ **Birthdate:** _____

**Family Doctor:** _____

**Allergies:** _____ **Today's Date:** _____

Help us take better care of you! Please bring this completed list, along with your medication bottles, to your next appointment at Billings Clinic. Your nurse or physician will review your medications, check for interactions, and will update your patient record. **Please carry a list of your medications with you at all times.** If there are any changes to your medications, please update the list. Please include:

- Medications prescribed by your doctor
- Medications you buy at the store
- Homeopathic medications
- Vitamins and/or herbal supplements

| **Medication** (Prescriptions, over-the-counter, vitamins, supplements) | **Dosage** (Amount: mg, ml, units, drops) | **Route** (Taken by mouth, injection, eye) | **Frequency** (How often do you take this?) | **Pharmacy/Store** (Where purchased) |
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**Billings Clinic**
2800 Tenth Avenue North
PO Box 37000
Billings, Montana 59107-7000
**www.billingsclinic.com**

If you need assistance completing this form or have questions about your medications or health, please call Billings Clinic HealthLine at **255-8400 or 1-800-252-1246.**