Medication Card

M.D. Prescribing	**Date Started**	**Name of Medicine** (brand name, generic name or over-the-counter name)	**Dose** mg, units, puffs or drops	**When Do You Take It?** How often? What time?	**Purpose** Why do you take it?
Cardholder's Name:	Phone:	Emergency Contact:	Phone:	Allergies To Medication and Reaction:	Moreland OB-GYN Associates, S.C.

Take this form to all doctor visits, when you go for any medical tests and hospital visits.
Keep this form up to date.
Write down any medications; cross out any medications no longer taken.