Personal Medication List

A list of **all the medications you take** is very important for the doctors and the healthcare team at the Cancer Centre. Please fill out this form **no more than 2 days** prior to your first appointment. Remember that vitamins and herbal or natural products are also important to list.

Please bring your completed form, along with all your supplements, herbals and vitamin bottles with you to your first appointment.

If you can't complete this form for any reason, a pharmacy staff member will help you do this at your first appointment.

Name: _____ Health card number: _____

Allergies: List everything you are allergic to and the symptoms of your allergic reaction

Name of substance *E.g. penicillin, peanuts, latex*	**Type of reaction** *E.g. rash, wheezing, lip swelling*
❑ Check this box if you have no allergies	

Medications: List all types of medicines, including vitamins and herbal products

1. Name of prescription medications *Medicines that your doctor prescribes, including those used only occasionally*	**Strength** *E.g. 50 mg*	**Directions** *E.g. 2 tablets in the morning or taken as needed*	**Purpose** *Why do you take it?*
❑ Check this box if you do not take any prescription medications			
Use the back of this form if there is not enough space to list all your prescription medications			

2. Name of non-prescription medications *Medicines purchased without a prescription, such as Tylenol, laxatives, allergy, cough and cold products*	**Directions** *How do you use this medication? e.g. couple of times a week*	**Purpose** *Why do you take it?*
❑ Check this box if you do not take any non-prescription medications		
Use the back of this form if there is not enough space to list all the non-prescription medicines you take		

3. Vitamins, minerals, herbal or natural products *E.g. St. John's Wort, calcium, multi-vitamins* **Brand name**	**Ingredients**	**Directions** *How do you take the product?*	**Used for how long?**	**Purpose** *Why do you take it?*
❑ Check this box if you do not take any vitamins, minerals, herbal or natural products				
Use the back of this form if there is not enough space to list all the vitamins, minerals, herbal or natural products you take				

Date completed: _____/_____/_____ Signature: _____
month day year

Medications: Continue to list types of medicines, including vitamins and herbal products you take

4. Name of prescription medications *Medicines that your doctor prescribes, including those used only occasionally*	**Strength** *E.g. 50 mg*	**Directions** *E.g. 2 tablets in the morning or taken as needed*	**Purpose** *Why do you take it?*

5. Name of non-prescription medications *Medicines purchased without a prescription, such as Tylenol, laxatives, allergy, cough and cold products*	**Directions** *How do you use this medication? e.g. couple of times a week*	**Purpose** *Why do you take it?*

6. Vitamins, minerals, herbal or natural products *E.g. St. John's Wort, calcium, multi-vitamins* **Brand name**	**Ingredients**	**Directions** *How do you take the product?*	**Used for how long?**	**Purpose** *Why do you take it?*

Please provide any other comments regarding medications that will help your cancer care team:
E.g. trouble opening child-resistant containers or trouble swallowing tablets

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Date completed: _____/_____/_____ Signature: _____
month day year