Name: _____ Date: _____	Penn Medicine Chester County Hospital **Home Medication List**

Do you have Nitroglycerin tablets or spray? □ Yes □ No

Have you used it since your cardiac event? □ Yes □ No If yes, how often? _____

Do you have any difficulty taking your medications? □ Yes □ No

If yes, explain: _____

Please list all medications that you are currently taking, including vitamins & supplements.

	Name of Medication	**Dosage**	**How often I take it each day**	**When do I take it?**	**Why I take it**
Example	**Tylenol**	**325 mg**	**Every 4 hours**	**As needed**	**headache**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Continue if needed on the other side

	Name of Medication	Dosage	How often I take it each day	When do I take it?	Why I take it
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					