MEDICATIONS

Name of Medication : _____

Dosage (mgs.)_____

How long have you taken it:_____

How often do you take it: ____AM ____Noon _____PM ____Other_____

Prescribed by:_____

Side effects:_____
NOTES:
_____

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Side effects:_____
NOTES:
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Over the Counter Medications
Vitamins Supplements

_____
_____
_____
_____
_____
_____

Allergies

_____
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_____
_____
_____

Pharmacy Phone Number_____
Name of Pharmacy/Location_____

_____

Questions for Doctor/ Response (use a recording device if available)

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