

Medication Record Form

Your Name and Address: _____

Your Primary Doctor: _____ Primary Doctor's Phone Number: _____

Other Doctors: _____ Other Doctor's Phone Number: _____

Your Pharmacy: _____ Pharmacy's Phone Number: _____

Your Health Problems: _____

Your Drug Allergies: _____

Write down the name of each medication you take, the reason you take it, how you take it, and the form (tablet, capsule, liquid), color and shape of the medication. In the last column, write down side effects and any special instructions your doctor or pharmacist have told you about. List all prescription medications and all over-the-counter medicines, including vitamins or other nutritional supplements, pain relievers, antacids, laxatives, and herbal remedies. Add new medicines when you start taking them. Carry this list with you at all times in your purse or wallet. Show this form to your doctors whenever you have an appointment. Bring this form with you to your pharmacy when you get a prescription filled. You may want to make copies of the blank form so you can use it again.

Name of Medication	Purpose or Reason Taken	Dose	Time(s) of day	Form, color, and shape	Side Effects or Special Instructions