MY MEDICATION RECORD

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Patient Name ________________________________ Primary Prescriber ____________________________

Pharmacy Name, Address, and Phone ____

Adverse Drug Reactions: ________________________ Allergies: ___________________________________

Medicine Name as listed on the medicine bottle)	**Other Name** Many medicines have a brand and generic name. Put the name NOT listed on the bottle in this column.	**Directions for Use** How many tablets and when to take	**Use** Why are you taking this or what is the medicine supposed to do?	**Prescriber** Name of the person who wrote you the prescription	**Other Information** Goals of therapy or things to avoid with the medicine.

Medicine Name as listed on the medicine bottle)	**Other Name** Many medicines have a brand and generic name. Put the name NOT listed on the bottle in this column.	**Directions for Use** How many tablets and when to take	**Use** Why are you taking this or what is the medicine supposed to do?	**Prescriber** Name of the person who wrote you the prescription	**Other Information** Goals of therapy or things to avoid with the medicine.

Last date updated ___________________________________