MY MEDICATION RECORD

For more information or to print additional copies, visit *www.generationrx.osu.edu*.

Patient Name _____ Primary Prescriber _____

Pharmacy Name, Address, and Phone _____

Adverse Drug Reactions: _____ Allergies: _____

Medicine Name (as listed on the medicine bottle)	**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)	**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.