PERSONAL MEDICATION RECORD

Last Name: _____ First Name _____

Date of Birth: _____ Gender: (circle one) Male Female

Allergies: _____

Physician: _____ Physician Phone #:_____

Pharmacy Name: _____ Street Name & City _____

Pharmacy Phone #: _____

Pharmacy Name: _____ Street Name & City _____

Pharmacy Phone # _____

Name of Medication (Prescriptions, over-the-counter, supplements, patches, inhalers)	**Dose/Strength of Medication** (Example: 20mg tablets)	**How Often Do You Take It?** (Example: 3 times a day at bedtime)	**Do You Still Take It? / If 'NO' - Date Stopped**
1.			Y N /
2.			Y N /
3.			Y N /
4.			Y N /
5.			Y N /
6.			Y N /
7.			Y N /
8.			Y N /
9.			Y N /
10.			Y N /
11.			Y N /
12.			Y N /
13.			Y N /
14.			Y N /
15.			Y N /
16.			Y N /
17.			Y N /

KEEP A COMPLETED AND UP-TO-DATE LIST WITH YOU AT ALL TIMES

Courtesy of Associates in Family Practice