Prescription Medications

USE PENCIL & update this list as need

Start Date	**Name of medicine** Brand name Generic name too, if available	**Dose** (mg, units, puffs, drops)	**When do you take it?** How many times per day? Morning and night? After meals?	**Purpose** Why do you take it?	**Important comments?** e.g. danger signs, side effects, drug-drug, drug-food interactions*	**Monitoring required** e.g. lab test every___weeks

*Always refer to physician and pharmacist input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions

Over-the-Counter medications

Check all that you use regularly

- ☐ Allergy relief, antihistamines
- ☐ Antacids
- ☐ Aspirin/other pain, headache, or fever relief
- ☐ Cold/cough medicines
- ☐ Diet pills
- ☐ Herbal, dietary supplements
- ☐ Laxatives
- ☐ Sleeping pills
- ☐ Vitamins, minerals
- ☐ Others (list below):

Allergies

Medication, Food, Environmental	**Adverse Reaction Experienced** (symptoms, severity, dates)

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Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.