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 #: ____________________

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)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
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9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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

Courtesy of Associates in Family Practice