Name: _____

DOB:_____

DRUG ALLERGIES:_____

_____

_____

Medication Chart

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.
Update this every time you visit.

Pharmacy Name _____

Pharmacy Number: _____

PRESCRIPTIONS

Name of medicine	**Dose (total milligrams)**	**How many times per day?**	**When do you take it? (Morning and night? After meals?)**	**Who prescribed it for you? (Physician's last name)**	**Why do you take it?**	**Do have any side-effects? Describe them.**
Over-the-counter medications, herbal remedies, vitamins						

Reviewed by Physician with Patient :_____ Date: _____