My Medication Record

List prescriptions. Over-the-counter drugs, vitamins, and herbal medicine.
Bring this form to doctor's appointments. emergency department or hospital visits.
If you have any complications with medications, immediately contact your doctor.

Date:__/__/___ Patient name:_____
Allergies:_____
Pharmacy name:_____Phone:(____)_____
Primary doctor name:_____Phone:(____)_____

Medication name/dose	Medication treats (condition):	Medication frequency:				Note/ question:
		Morning	Afternoon	Evening	Bedtime	