My Medication Record

Name _____

Allergies _____ No known drug allergies ☐

Primary care doctor or practitioner _____ Tel: ( )_____

Pharmacy 1 _____ Tel: ( )_____

Pharmacy 2 _____ Tel: ( )_____

Medicine (include strength, dose and frequency)	**Prescribed By**	**Purpose**	**Start Date**	**Times to Take** Morn	Noon	Eve	Bed

✻ Questions to ask your doctor/practitioner

- Why am I taking this medicine?
- How long am I going to take it?
- Should I take it on an empty stomach or with food?
- What should I do if I forget to take it?
- What side effects should I look for?
- Is it safe to drink alcohol with it?
- Under what circumstances should I call you?
- Could I save money by using a generic drug that would be equally effective?

Definitions

Generic medicine: A drug that has the same medicine as the brand name drug. This will work the same way as the brand name drug but often costs less.

Prescription medicine: A drug that can only be bought with permission from the doctor.

Start date: The date that you first started taking this medication.

* *Read medication labels carefully. Record herbal and other supplements you are taking on the reverse side of this form.*

** *Maintain this medication record with your other important medical documents. Keep it updated and with you at all times.*

Notes

Meeting or phone call with: **Date:**