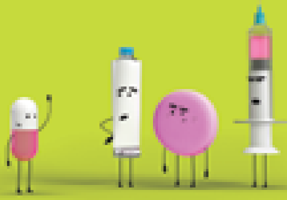

Medication Record

Update this record each time you add or stop taking a medication, or when you change your dose. Include all prescription and over-the-counter drugs, vitamins and supplements.

Your name: ______________________

Date you last updated this form: ______________________

Indicate any allergies or intolerances: ______________________

Emergency contact

Name: ______________________

Phone number: ______________________

Bring this record to your doctor, pharmacist or other health care provider when you are reviewing your medications or have concerns that new symptoms may be a result of a drug you are taking.

Your list of medications should be reviewed regularly to see if you still need all the drugs you are taking.

Medication name (brand name/generic name)	Form (pill, liquid, patch, eye drops etc.)	Dosage and instructions	Reason for use	Prescribed by	Start date	Stop date
E.g. Lipitor / atorvastatin	E.g. Pill	E.g. 20 mg, once a day	E.g. High cholesterol	E.g. Dr. Smith	Feb. 12, 2018	Mar. 12, 2018