

MEDICATIONS

Please use pencil to complete this form.

Name

Start Date	Name of Medication	Prescribed By	Dosage	When is the Medication Taken	Purpose	Danger Signs*	Stop Date	Monitoring Required	Notes/ Changes
mm/dd/yy	Brand and Generic name (If available)		mg/ units/ puffs/ drops	How many times per day? Morning and/or night? After meals?		Call Immediately if you experience any of these signs	mm/dd/yy	e.g. lab test every ___ weeks	Patient Have you experienced any side effects? If stopped taking, why? Doctor Identify drugs and/or food that may cause interactions. Date list was reviewed/updated
1/01/06	Medication ABC	Dr. ABC	5 mg	2 times, morning and night	Ulcer			Blood Test Every 4 weeks	6/15/06 – Reviewed by Dr. ABC, Changed Dosage to 10mg

* Always refer to physician and pharmacist input and the detailed drug sheets provided with each medication for a complete list of potential side effects/danger signs/interactions. Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list. After any hospitalization, check with your doctor to review this medication list.