My Medication Record

Name: ____________________ **Birth date:** ____________________ **Pharmacy:** ____________________

Include all of your medications on this record: prescription medications, nonprescription medications, herbal products, and other dietary supplements. Always carry your medication record with you and show it to all your doctors, pharmacists and other healthcare providers.

Drug		Take for...	When do I take it?				Start Date	Stop Date	Doctor	Special Instructions
Name	Dose		Morning	Noon	Evening	Bedtime				

Drug Allergies and Reactions: ____________________

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Date last updated: ____________________