Medication Chart

To better care for you, please tell us what prescriptions and over-the-counter medications you take.
Update this every time you visit.

Pt Name: _____ Review date: _____

Prescriptions				
Name of medicine	**Dosage and frequency**	**When do you take it? (Morning and night? After meals?)**	**Who prescribed it for you? (Physician's last name)**	**Why do you take it?**
Over-the-counter medications, herbal remedies, vitamins				