My Medicine Record

List all the medications you take.

PRESCRIPTION MEDICATIONS:	List how many times taken in a day and dose					
Medicine*	**Morning**	**Lunch**	**Dinner**	**Bedtime**	**Special Instructions**	**Reason for taking?**

*When your doctor changes or stops your medicine, draw a line through the old information.

List all of the over-the-counter medicines and supplements you are taking. These include pain relievers, antacids, cough or cold medicine, antihistamines, allergy medicines, sleeping pills, laxatives or diarrhea medicine, vitamins, or herbal supplements.

OTC or Herbal Medicine*	Reason for taking?

List all of your drug allergies.

Drug Allergies

*When your doctor changes or stops your medicine, draw a line through the old information.

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