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Medication Chart

Help us care for you better by telling us what prescriptions and over-the-counter medications you take. Update this every time you visit.

Patient Name_____D.O.B._____Date_____

Prescriptions						
Name of medicine	**Dose (total milligrams)**	**How many times per day?**	**When do take it? (Morning and night? After meals?)**	**Who prescribed it for you? (Physician's last name)**	**Why do you take it?**	**Do have any side-effects? Describe them.**
Over-the-counter medications, herbal remedies, vitamins						