



Name & Phone Number: _____

Date Updated: _____

Food & Drug Allergies: _____

My **PRESCRIPTION** medications are

Name of Drug	What It's for	Strength/ Dose	Color/ Shape	How Often You Take It & When	Doctor Who Prescribed It	Date Started	Special Instructions
SAMPLE: Lipitor	<i>Cholesterol</i>	<i>10 mg</i>	<i>White, Oval</i>	<i>1 each day</i>	<i>Dr. Jones</i>	<i>5/24/2007</i>	<i>No grapefruit</i>



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My **Over-the-Counter** medications, **Vitamins**, and **Herbal Supplements** are

Name	Why You Take It	Strength/ Dose	How Often You Take It & When	Doctor Who Recommended It, If Any	Date Started	Does It Work?
SAMPLE: Advil	Arthritis pain	200 mg	Twice daily		01/29/2001	Yes