Medication Chart

Help us care for you better by telling us what prescriptions and over-the-counter medications you take. Please include herbal remedies and vitamins. List medication allergies at the bottom. Update this every time you visit.

Patient's Name _____ Date _____

Name of Medication	Dose	How many times per day?	Why do you take it?

DRUG ALLERGIES

Name of Drug	What happens if you take it?	Name of Drug	What happens if you take it?

Surgeries and Hospitalizations	Date