

Name: \_\_\_\_\_

# MEDICATION LOG

Date: \_\_\_\_\_

- Please list all of the medications that you are currently taking, and any medications that you have taken in the last 6 months.
- Be sure to include any over-the-counter medications, vitamins, aspirins, herbal supplements, etc. that you take regularly.
- Please list the approximate start date of each medication (please put down your best guess), and list the date you stopped taking them if you are not taking them now.
- If you are still taking the medication(s), please disregard the stop date.

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_

Medication : \_\_\_\_\_

Dose (mgs): \_\_\_\_\_ Start date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How often do you take it?: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Name of prescribing doctor: \_\_\_\_\_