

Medicine Record Form

Prescription Medicines

Name and Strength of Medicine	Physician	Date Began Taking/Why	How Much To Take and What Time of Day	Do Not Take With

Non-Prescription Medicines, Vitamins, Herbals, Supplements

<input type="checkbox"/> Cold or cough medicine <input type="checkbox"/> Aspirin or other pain reliever <input type="checkbox"/> Allergy relief medicine <input type="checkbox"/> Antacids <input type="checkbox"/> Sleeping pills <input type="checkbox"/> Laxatives	<input type="checkbox"/> Diet pills <input type="checkbox"/> Others _____ <input type="checkbox"/> Vitamins (type) _____ _____ _____	Medicines that produce bad reactions or allergies for me: _____ _____ _____
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