



Review of regular medications

Prescription drugs

Name: _____ **Strength:** _____ (mg, mcg, etc.)

Frequency/Times of day: _____ Date began: _____

Special directions (e.g., with food) and cautions (e.g., no alcohol): _____

Reason: _____

Prescribed by (name of doctor): _____

From (pharmacy): _____ Refills (circle): 1 2 3 4 5 6 New refill needed

Issues to discuss at my next appointment: _____

Name: _____ **Strength:** _____ (mg, mcg, etc.)

Frequency/Times of day: _____ Date began: _____

Special directions (e.g., with food) and cautions (e.g., no alcohol): _____

Reason: _____

Prescribed by (name of doctor): _____

From (pharmacy): _____ Refills (circle): 1 2 3 4 5 6 New refill needed

Issues to discuss at my next appointment: _____

Name: _____ **Strength:** _____ (mg, mcg, etc.)

Frequency/Times of day: _____ Date began: _____

Special directions (e.g., with food) and cautions (e.g., no alcohol): _____

Reason: _____

Prescribed by (name of doctor): _____

From (pharmacy): _____ Refills (circle): 1 2 3 4 5 6 New refill needed

Issues to discuss at my next appointment: _____



Review of regular medications

Over-the-counter medicines (Non-prescription)

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
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Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician



Review of regular supplements

Vitamins, herbals, dietary supplements

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician

Name: _____ **Strength:** _____ (mg, mcg, etc.)
Frequency/Times of day: _____ **Date began:** _____
Reason: _____

Suggested by: _____ Informed my physician