

Review of regular medications

Prescription arugs		
Name:	Strength:	(mg, mcg, etc.)
Frequency/Times of day:	Date began:	
Special directions (e.g., with food) and cau	utions (e.g., no alcohol):	
Reason:		
Prescribed by (name of doctor):		
From (pharmacy):		
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 cau	utions (e.g., no alcohol):	
Reason:		
Prescribed by (name of doctor):		
From (pharmacy):	Refills (circle): 1 2 3 4 5 6	New refill needed \square
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 cau	utions (e.g., no alcohol):	
Reason:		
Prescribed by (name of doctor):		
From (pharmacy):		
Issues to discuss at my next appointment:		



Review of regular medications

Over-the-counter medicines (Non-prescription)

Name: Frequency/Times of day:	_ Date began:	(mg, mcg, etc.)
Reason:		
Suggested by:		☐ Informed my physician
Name:	Strength:	(mg, mcg, etc.)
Frequency/Times of day:Reason:	_ Date began:	
Suggested by:		_ ☐ Informed my physician
Name: Frequency/Times of day: Reason:	_ Date began:	
Suggested by:		☐ Informed my physician
Name:	_ Date began:	(mg, mcg, etc.)
Suggested by:		☐ Informed my physician
Name:	Date began:	(mg, mcg, etc.)
Suggested by:		_ ☐ Informed my physician



Review of regular supplements

Vitamins, herbals, dietary supplements Name: ______ Strength: _____ (mg, mcg, etc.) Frequency/Times of day: _____ Date began: ____ Name: Strength: (mg, mcg, etc.) Frequency/Times of day: _____ Date began: ____ Name: Strength: (mg, mcg, etc.) Frequency/Times of day: _____ Date began: _____ Reason: Suggested by: Strength: (mg, mcg, etc.) Frequency/Times of day: Date began: Name: Strength: (mg, mcg, etc.) Frequency/Times of day: _____ Date began: ____