national council on aging

My Medication Record

Name:_____ Tel #:_____

Age:_____Address: _____

Primary Doctor:_____ Primary Doctor's Phone Number:_____

Specialist: _____ Specialist's Phone Number: _____

Pharmacy Name:_____ Pharmacy's Phone Number:_____

Diagnoses and Conditions: _____

Recent History/Problems:_____

Drug Allergies:_____

Name of Medication	Purpose or Reason Taken	Dose	Time(s) of day	Special Instructions or Side effects to be aware of

If needed, use another form for additional medications.