Personal Medication Record

My Information

Name: _____

Allergies: _____

Doctors:

Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

Pharmacy:

Name: _____

Phone: _____

Current Medications

Name	Strength	Dose	How Often	Reason to Take	Prescribing Doctor	Start Date
Example: Atenolol	*25 mg*	*1 Pill*	*Daily in the morning*	*High Blood Pressure*	*Dr. Smith*	*1/5/22*