My Medication Profile

Name_____

Prescription Drugs:

Name of Medication	Prescribing Doctor	Strength (as in mg)	Dosage Form (pill or liquid)	Directions for use (number of times per day; if you take with or before a meal, etc).	Reason for taking	Start date

Over-the-Counter Pills and Supplements:

Name of Medication or Supplement	Prescribing Doctor (if applicable)	Strength (as in mg)	Dosage Form (pill or liquid)	Directions for use (number of times per day; if you take with or before a meal, etc).	Reason for taking	Start date