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Prescription Medicines for _____

Write down the names of any prescription medicines that the person in your care is taking and the health condition for which they were prescribed. If he or she stops taking a medicine, simply write down the reason in the space provided. You can write down any allergies to prescription medicines at the bottom of this form.

Medicine	Dosage amount	How/when to take	Why he/she takes it	Prescribing physician	Pharmacy
	Number of pills, capsules, drops, etc.				
		Time(s) to take medicine	If stopped, provide reason	Phone number	Phone number
	Number of pills, capsules, drops, etc.				
		Time(s) to take medicine	If stopped, provide reason	Phone number	Phone number
	Number of pills, capsules, drops, etc.				
		Time(s) to take medicine	If stopped, provide reason	Phone number	Phone number

If the person in your care is allergic to any specific prescription medicines, please list them here.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Over-the-Counter Medicines for _____

Write down the names of any over-the-counter medicines that the person in your care is taking and the reason he or she takes them. If he or she stops taking a medicine, simply write down the reason in the space provided. You can write down any allergies to over-the-counter medicines at the bottom of this form.

Over-the-counter medicine	Dosage amount	How/when to take	Why he/she takes it	Recommending physician
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number

If the person in your care is allergic to any specific over-the-counter medicines, please list them here.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Vitamins, Supplements, and Herbals for ________________

Write down the names of any vitamins, supplements, or herbals that the person in your care is taking and the reason he or she takes them. If he or she stops taking a vitamin, supplement, or herbal, simply write down the reason in the space provided.

Vitamin/supplement/herbal	Dosage amount	How/when to take	Why he/she takes it	Recommending physician
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number
	Number of pills, capsules, drops, etc.		Recommended by health care provider? ☐ Yes ☐ No	
		Time(s) to take medicine	If stopped, provide reason	Phone number

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Notes