## MEDICATION LOG

N LOG NAME: \_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_ ALLERGIES: \_\_\_\_\_

**EMERGENCY CONTACT/PHONE NUMBER:** 

PHONE NUMBER: \_\_\_\_\_

\_\_\_\_\_\_#\_\_\_\_\_\_

List ALL medications that you use: Prescription and over the counter medicines, herbal medications, and dietary supplements; in the form of pills, inhalers, creams, suppositories, etc.

NAME AND DOSE OF MEDICATION	THIS MEDICATION IS FOR MY:	APPEARANCE (type, shape, color)	HOW MANY? HOW OFTEN?	HOW TAKEN?	DATE STARTED/ ENDED	PRESCRIBER NAME/CONTACT INFORMATION	NOTES
EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:
Ibuprofen 200mg	Back pain	Tablet, round,	1 tablet every	By mouth, with	11/01/2020	Dr. Johnson	Take as needed
		brown	4-6 hours	water	11/10/2020	(414) 555-5555	

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