h2U HEALTH TO YOU

Patient Medication List

Name: _____

Date: _____

Medication Allergies:

_____

_____

_____

Prescriptions						
Name	**Dose**	**How many times per day?**	**When do you take it? (Morning, night, After meals?)**	**Who prescribed it? (Physician's last name)**	**Why do you take it?**	**Do have any side effects? Describe them.**

Over-the-counter medications, herbal remedies, vitamins						
Name	**Dose**	**How many times per day?**	**When do you take it? (Morning, night, After meals?)**	**Who recommended it?**	**Why do you take it?**	**Do have any side effects? Describe them.**