Carmella Rose Health Foundation

www.carmellarose.org
216.658.6025

Personal Medication Record

Name _____ **Date**_____

List all of the medicine you take (prescriptions, over-the-counter, vitamins, herbal supplements)

Name of medicine List the names for this medicine that are on the bottle (brand and generic)	**What does this medicine look like?** Color, shape Is it a pill, liquid, patch, shot	**Dose** (strength of the medicine)	**What are the directions?** (when do you take it?)	**Why do you take this medicine?**	**How long have you been taking this medicine?**	**Questions or comments**
SAMPLE Made up drug name	*orange oval (or draw it) pill*	*25 mg*	*2 times a day morning and bedtime*	*arthritis*	*3 years*	*Should I take less?*