Patient Name ______________________

Date of Birth: ______________________

Date of Visit: ______________________

Prescribed Medicines From Your Doctor

Medicine Name	Dose	Frequency	Why Taking?	Expired? Y/N	Need Refill? Y/N	Taking as Prescribed? Y/N

Over-the-Counter Medicines, Such as Vitamins, Herbal Medicines, and Cold Medicine

Medicine Name	Dose	Frequency	Why Taking?