My Medicine Record

Complete and bring it to your first MTM meeting. You may find it necessary to contact your primary care provider to obtain all medication information.

Name: _____

DOB: _____

Date: _____

Allergic to: _____

List all medicines you are currently taking. Include prescriptions, over-the –counter medications and herbals. Include medications taken as needed (examples: nitroglycerin, inhalers)

Start date	Name of Generic or Brand PX or OTC medication	Dose and Directions	Reason for Taking	Date Stopped

Important contact information:

Doctor's Name:
Clinic Name:
Phone Number:
Pharmacist's Name:
Pharmacy Name:
Phone Number:
Emergency contact:
Phone Number: