SAMPLE FORM

Start Date	Stop Date	Medication	Prescribing Doctor	Purpose	Response			
Month/day/year	Month/day/year	Generic & trade name(s)	Doctor's name, location & phone	Diagnosis, symptom(s)	Did the medication help or not?			
Month/day/year	Month/day/year	Generic & trade name(s)	Doctor's name, location & phone	Diagnosis, symptom(s)	Did the medication help or not?			
Month/day/year	Month/day/year	Generic & trade name(s)	Doctor's name, location & phone	Diagnosis, symptom(s)	Did the medication help or not?			
				DIRECTIONS				
				Use this page to record the medications you take over time. Include the following: • prescription medications your doctor(s) prescribe(s) • over-the-counter medications your doctor(s) recommend(s) • over-the-counter medications you take on your own, if any Use this page as a master. You can make as many copies of it as you wish. You can make separate pages for other family members. For each medication, record the following: I. The date(s) on which you started the medication—and the date(s) on which you stopped it, if applicable.				
			• over-the					
			it as you wi					
			I. The date(s) date(s) on					
			and his/her	2. The doctor who prescribed or recommended it, if applicable, and his/her location and phone number. 3. Why the medication was prescribed was prescribed or recommended—the diagnosis or symptom(s).				
			recommend					
			·	4. Your response to the medication.				
			Keep the co	mpleted forms for future reference	2.			

Medication History _____

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