National Council on Aging

My Medication Record

Name: _____ Tel #: _____ Age: _____

Address: _____

Primary Doctor: _____ Primary Doctor's Phone Number: _____

Specialist: _____ Specialist's Phone Number: _____

Pharmacy Name: _____ Pharmacy's Phone Number: _____

Diagnoses and Conditions: _____

Recent History/Problems: _____

Drug Allergies: _____

Name of Medication	Purpose or Reason Taken	Dose	Time(s) of day	Special Instructions or Side effects to be aware of

If needed, use another form for additional medications.

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