

Medication Management Form

Patient name: _____

Date of birth: _____

Local pharmacy name: _____

Pharmacy phone number: _____

Local pharmacy address: _____

Mail order company name: _____

Company phone number: _____

Name of Medication Brand or Generic	Dosage (mg. units, puffs, drops)	When to take it? Times per day? AM or PM? With meals?	Why take it?	Start Date	Stop Date	Monitoring Required (e.g. lab test every _____ weeks)	Prescribed By	Side Effects / Danger Signs

Over-the-Counter Medications (check all that your family member uses regularly)

- Allergy relief, antihistamines
- Cold / cough medicines
- Laxatives
- Other (list below): _____
- Antacids
- Diet pills
- Sleeping pills
- Aspirin / other relief for pain, headache, or fever
- Herbals, dietary supplements
- Vitamins, minerals