MEDICATION MANAGEMENT RECORD

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Local Pharmacy Name & Number: _____

Mail Order Pharmacy Name & Number: _____

Prescribed medication:	**Prescribing Dr. & phone #:**	**For what condition?**	**Dose per pill**	**How/when it's taken:**	**Date Prescribed:**	**End Date (if any)**	**Any negative reactions**
SAMPLE Medication	*Dr. Who; 999-999-9999*	*Blood Pressure*	*.25 mg*	*AM; By mouth*	*01-01-1996*	*01-01-1996*	*N/A*

Prescribed medication:	**Prescribing Dr. & phone #:**	**For what condition?**	**Dose per pill**	**How/when it's taken:**	**Date Prescribed:**	**End Date (if any)**	**Any negative reactions**
SAMPLE Medication	*Dr. Who; 999-999-9999*	*Blood Pressure*	*.25 mg*	*AM; By mouth*	*01-01-1996*	*01-01-1996*	*N/A*

Patient Name: _____