

TROY FAMILY PRACTICE

2041 E. Square Lake Rd. Suite 300
Troy, Michigan 48085
(248) 813-0124

Physician: _____

PERSONAL MEDICATION RECORD

Name: _____ Date of Birth: _____

Allergies: _____

Primary Pharmacy: _____ Pharmacy Phone #: _____

Name of Medication: <small>(Prescriptions, over-the-counter, eye drops, supplements, patches, herbals, inhalers, implanted pumps)</small>	Dose of Medication: <small>(Example: One 20 mg tablet)</small>	How Often Do You Take This Medication? <small>(Examples: three times a day, at bedtime)</small>
1.		
2.		
3.		
4.		
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6.		
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18.		
19.		
20.		

* Please remember to update this form and contact your physician whenever changes to your medications are made. * Always document to keep a record for yourself and your healthcare provider. *

Name of person updating this form:	Date:	Relationship to Patient:

