TROY FAMILY PRACTICE

Physician: _____

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

PERSONAL MEDICATION RECORD

Name: _____ **Date of Birth:_____**

Allergies: _____

Primary Pharmacy: _____ Pharmacy Phone #: _____

Name of Medication: (Prescriptions, over-the-counter, eye drops, supplements, patches, herbals, inhalers, implanted pumps)	**Dose of Medication:** (Example: One 20 mg tablet)	**How Often Do You Take This Medication?** (Examples: three times a day, at bedtime)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
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10.		
11.		
12.		
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17.		
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 health care provider. *

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