Patient Better®

My Medication List

Patient Name: _____

A Simple Table to Track Your Medications, Doses, and Daily Use

Medication Name	Dose	How Often You Take It	Why You Take It (Condition)	Prescribing Clinician	Start Date	Notes (Side Effects, Changes, Interactions)

Completed By (If Not the Patient): _____ Date: _____

Medication Safety & Pharmacy Information

Pharmacy Name	Phone Number	Address	Notes

Known Drug Allergies	Past Medications That Didn’t Work