**Medication Schedule Printable**

* **List all prescriptions, over-the-counter drug, vitamins and herbs.**
* **Bring this to every doctor’s appointment and if you go to the emergency room or hospital**  Date:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name and Dose of Your Medicine** | **This Medicine**  **is for**  **my\_\_\_\_\_\_\_\_\_\_\_\_** | **How Much and How Often?** | | | | **Reminder:**  **When do I take it?** |
|  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**If you have any problems with you medicine – do not wait. Talk to your health care provider right away.**

**Name of Primary Primary Care Provider**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**