Allergy & Asthma Consultants, L.L.P.
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Personal Medication Record for: _____

Use this form to record all medications you are taking. Be sure to update the list when you start taking a new medicine.

PRESCRIPTION MEDICATIONS

Name	Why do you take it? (Your medical condition)	Dosage Medication Strength Number of times you take it daily	How do you take? Time of day. With or without food?	Prescribing Doctor
Example: Benadryl	Allergies	25 mg once daily	At bedtime	Dr. Smith

OVER THE COUNTER MEDICINES (Including vitamins and herbal products)

Name	Why do you take it? (Your medical condition)	Dosage Medication Strength Number of times you take it daily	How do you take? Time of day. With or without food?	Prescribing Doctor
Example: Tylenol	Arthritis Pain	1000 mg (2 tablets) every 6 hours	As needed	None