Medication List

Medications are an important part of your care. Before your next appointment with your physician(s), please complete this form as fully as possible.

NAME OF MEDICATION	STRENGTH OF MEDICINE OR STRENGTH OF EACH PILL	WHEN TAKEN (TIME OF DAY)	# OF PILLS TAKEN AT EACH DOSE OR DOSE PRESCRIBED	PURPOSE OF MEDICINE	DATE STARTED	DOCTOR WHO ORDERED	DATE NEW PRESCRIPTION NEEDED
Drug X	*20 mg*	*1pm and 5pm*	*2*	*Blood Pressure Control*	*1/4/03*	*Dr. X*	*8/30/03*
Drug Y	*80 mg*	*8am*	*1*	*Pain Reliever*	*6/30/03*	*Dr. Y*	*8/30/03*