

Taking Stock of Your Medications

Date: _____

Patient Name: _____

Date of Birth: ____/____/____

Your health is important – to you and to your loved ones. If you’re like many people, though, you may not always take your medicines as discussed, and that can put your health at risk.

Please complete the medication checklist below as completely as you can and share it with your doctor.

Getting started is easy. Simply:

- List all the medicines you have been asked to take by any healthcare professional. Include any medicines you buy without a prescription, such as aspirin or ibuprofen. In the separate space provided, list any vitamins or supplements you take.
- If you don’t know the name of a medicine, provide as many details as you can, such as the dosage, the condition it’s for or the color, shape, and size of the pill.

Name/Description	Schedule 1x day, 2x day, weekly, as needed, etc.	How Often Taken				Reason for Not Taking Check All That Apply									
		Every time without fail	Almost always	Most of the time	Sometimes/ hardly ever	Forget	Side effects*	Cost	Take too many pills	Don't like to take medicine	Can't get to Pharmacy	Not sure why I need to take	Not filled/ refilled	Other	
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															

*Please report any medication side effects to the manufacturer in question.

Please list any vitamins/supplements and the dosage you take: _____

