Stay Healthy

Name: _____

Date: _____

MEDICATION TRACKER

Keep track of your medications. List all prescription medications, including any medicine samples you are given. Include all over-the-counter medications and dietary supplements (including vitamins, minerals and herbals) you use, whether you use them all the time or only some of the time.

Medication Name	**Dosage** (how much)	**Frequency** (how often) & what time)	**Purpose** (what is medicine for)	**Date Started**	**Refill Date**	**Prescribing Doctor**	**Pharmacy Phone Number**

For more information or to arrange for our services, please call **1.888.9.GET.HELP** or visit **partnersincareny.org**

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