

Medication Record

Name _____ Date _____ Completed by _____

Primary physician's name _____ Physician's telephone number _____

Prescribed Medication	What Is It For?	Pill Size (e.g., 5mg, 1 capsule)	Color and Shape	Time Taken (e.g., 8 a.m., 12 noon)	Concerns or Problems	Compliance (e.g., always, sometimes, never)