

My Medications



Please list all medications, including those prescribed by your doctor and those purchased over the counter. Place an "X" through any discontinued medications and make a note of the reason it was stopped.

Name: _____

Dose: _____

How Often: _____

Date Ended/Reason: _____

Name: _____

Dose: _____

How Often: _____

Date Ended/Reason: _____

Name: _____

Dose: _____

How Often: _____

Date Ended/Reason: _____

Name: _____

Dose: _____

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