Breezewood Family Healthcare, PA

Medication Chart

Help us care for you better by telling us what prescriptions and over-the-counter medications you take. Update this every time you visit.

Name: _____

Provider name: _____

Prescriptions						
Name of medicine	**Dose** (Total mgs)	**No. of times per day?**	**When do you take it?** (AM and PM? After meals?)	**Who prescribed it for you?** (Physician's last name)	**Why do you take it?**	**Do you have any side-effects? Describe them.**