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.**
SUPPLEMENTS						