Name ______________________
Date of Birth ______________________
Address ______________________
Drug Allergies ______________________

Primary Care Provider ______________________
Primary Care Phone Number ______________________
Pharmacy ______________________
Pharmacy Phone Number ______________________

Medication and Supplement Tracker

Start Date	Name	Dose	Instructions	Reason	Prescribing Provider	Notes	Stop Date

CATEGORIES:

- **Start Date:** When did you begin taking this medication?
- **Name:** What is the brand name? What is the generic name?
- **Dose:** What amount (mg, drops, units, etc.) do you take at one time?
- **Instructions:** How often do you take the listed dose? Daily? Two times daily? As needed?
- **Reason:** What medical condition do you take this for?
- **Prescribing Provider:** Who follows your care while on this medication/ supplement?
- **Notes:** Do you need lab monitoring? Do you need refills? Do you experience side effects?
- **Stop Date:** Is this medication discontinued?

Do not start new medications or supplements without talking to your care team first. Alert them of any new signs, symptoms, or side effects that might occur.