RECORD OF MEDICATION

Patient / Client Name: _____

Medication and Dosage	Prescribed By	Start Date	Purpose	Side Effects	Changes (↑, ↓, DC)	Date of Changes

Primary Care Physician: _____ **Date of Last Physical Exam:** _____

Address: _____

Phone Number: _____ **Fax:** _____

Psychiatrist: _____

Address: _____

Phone Number: _____ **Fax:** _____