

Clients Medication Record

Name and Address: _____

Primary Doctor: _____ Primary Doctors' Phone Number(s): _____

Other Doctor(s): _____ Other Doctor's Phone Number(s): _____

Pharmacy: _____ Pharmacy's Phone Number: _____

Health Problems: _____

Drug Allergies: _____

Emergency Contact: _____ Relationship: _____ Phone # _____

(Please list all vitamins and over the counter drugs also.)

Name of Drug	Reason	Color/ Shape	Date start	Date stop	Doctor	Dosage	Instructions

(Please keep an updated copy in the client's chart and bring one to every medical appointment.)