



MY MEDICATION RECORD

For more information or to print additional copies, visit www.generationrx.org/toolkits/older-adult.

Patient Name _____ Primary Doctor _____

Pharmacy Name, Address, and Phone _____

Adverse Drug Reactions: _____ Allergies: _____

Medicine Name as listed on the medicine bottle)	Other Name Many medicines have a brand and generic name. Put the name NOT listed on the bottle in this column.	Directions for Use How many tablets and when to take	Use Why are you taking this or what is the medicine supposed to do?	Prescriber Name of the person who wrote you the prescription	Other Information Goals of therapy or things to avoid with the medicine.

