**ADVANCED REHAB, PC - Medications**

**NAME:** ______________________________

**KEEP A RECORD OF MEDICINES YOU USE** **LIST YOUR PRESCRIPTION MEDICINE BELOW**

| Check boxes for the ones you use: | Date | Name of medicine | How much do I take | When do I take it | What do I use it for | Refills |
|---|---|---|---|---|---|---|
| *Example* | *01//01/13* | *XXXX* | *1 tablet 400 mg* | *3x/day after meals* | *Arthritis* | 2 |
| ☐ Aspirin or other pain/ headache/ fever medicine | | | | | | |
| ☐ Allergy medicine | | | | | | |
| ☐ Antacids | | | | | | |
| ☐ Blood pressure | | | | | | |
| ☐ Blood thinners | | | | | | |
| ☐ Cold medicine | | | | | | |
| ☐ Cough medicine | | | | | | |
| ☐ Diet pills/Supplements | | | | | | |
| ☐ Laxatives | | | | | | |
| ☐ Sleeping pills | | | | | | |
| ☐ Vitamins | | | | | | |
| ☐ Minerals | | | | | | |
| ☐ Herbals | | | | | | |
| ☐ Others – List Below: | | | | | | |
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