beacon health options

Medication Form

Bring to ALL Doctor Appointments

Name: _____ **Allergies:** _____ **Date:** _____

This form helps you and your family members remember the medications you are taking and why you are taking them. The form also provides doctors and other professional's information on the medications you are taking. Bring this with you to all your doctor appointments. The more you and your healthcare provider know about your medications the safer your health care will be.

Prescription Medicines

Date Medication started	Date Medication stopped	Name of Medicine	Dose (Examples mg, ml units, drops)	When do I take this medicine? (check time)					Why do I take it?	Which doctor is prescribing this?
				AM	Noon	PM	Bed Time	With Food		
Draw a line through the medications you have stopped taking. Write in the date you stopped taking it.										

*Turn Over to complete the Over-the-Counter Medication list on the back page

Over-the-Counter Medicines (such as herbals, vitamins, antacids, aspirin)

Date Medication started	Date Medication stopped	Name of Medicine	Dose (Examples mg, ml units, drops)	When do I take this medicine? (check time)					Why do I take it?	Which doctor is prescribing this?
				AM	Noon	PM	Bed Time	With Food		
Draw a line through the medications you have stopped taking. Write in the date you stopped taking it.										

Please let your Case Manager know if you need help in filling out this form.

Thank you,
Case Management Services
Beacon Health Options