UNIVERSAL MEDICATION FORM

Name: _____________________________ Birth Date: _______________Date List Updated: ___________

Allergies: ____

1. Please start with medications for your major problems such as, diabetes, high blood pressure, heart, cholesterol, seizures, etc. **Write names of medication as they appear on the bottle.**
2. TRY TO LIST ALL MEDICATION OF ONE DISEASE (LIKE DIABETES) TOGETHER.
3. In the last 1 or 2 lines, please write all over the counter supplements/ vitamins/ herbs.

MEDICATION	DOSE	DIRECTIONS	REASON	DOCTOR