

Patient Name: _____ Date: _____

Consulting Physician(s) APN: _____ Pharmacy Phone: _____

_____ Allergies: _____

_____ Medical/Surgical #'s _____

Drug Sensitivities: _____

Medication	Dosage	AM	AM	AM	AM	AM	PRN	Times/ Day	Total Dosage	Taken For/ Diagnosis	Notes Prescribed By:	Disc.
		PM	PM	PM	PM	PM						
Daily Medications												
PRN Medications												
OTC Medications												

Lexicon: PRN – As Needed; *OTC* – Over the Counter; *AM* – morning; *PM* – evening; *D/C* – discontinued; *QD* – once per day; *BID* – twice per day; *TID* – three times per day; *QID* – four times per day; *q2h* – every 2 hours; *q3h* – every 3 hours. etc.

Patient Name: _____

Date: _____

Con't

<i>My Journal</i>				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Notes:

Food: