



# Medicine Profile

**Patient:** \_\_\_\_\_ **Doctor:** \_\_\_\_\_ **Pharmacy:** \_\_\_\_\_  
 address: \_\_\_\_\_ address: \_\_\_\_\_ address: \_\_\_\_\_  
 phone #: \_\_\_\_\_ phone #: \_\_\_\_\_ phone #: \_\_\_\_\_  
**Allergies:** \_\_\_\_\_

Prescription drugs I take:

Drug name	Why I take it	How much I take	Number of times a day I take it	Time of day I take it (hour)	Comments, side effects, how long to take, etc.
			1 2 3 4		

Over-the-counter drugs, supplements or herbal medicines I take:

Drug name	Why I take it	How much I take	Number of times a day I take it	Time of day I take it (hour)	Comments, side effects, how long to take, etc.
			1 2 3 4		