The routine for taking my medicine is...

Name of patient: _____   **Date:** _____

Healthcare provider: _____

Physician's name: _____   **Name of medicine:** _____

How much/Dosage: **With or Without meals:**

When to take it:

How many days to take it:

Month: _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

The medicine is for:

Pain	Sneezing/Cold Symptoms	Fever	Fatigue	Headache
Oral Health	Blood Pressure	Stomach	Itchy Skin	Diabetes

Other:

Does this medicine interfere with other medication I am already taking?: