



# Personal Medication Record

Medication and dosage	Date begun	Reason for stopping	Date stopped	Prescribed by	Side effects	Did it work? Yes/No/Maybe	Cost		
							Actual	Covered by Insurance	My cost

Any allergies to medicines \_\_\_\_\_

Preferred pharmacy \_\_\_\_\_ Telephone number \_\_\_\_\_

Insurance company \_\_\_\_\_ Case manager \_\_\_\_\_ Telephone number \_\_\_\_\_

Policy number \_\_\_\_\_ Address to file claims \_\_\_\_\_

Notes \_\_\_\_\_