

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:** _____

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

Notes:

Food: