**Medication Schedule**

* **List all prescriptions, over-the-counter drug, vitamins and herbs.**
* **Bring this to every doctor’s appointment and if you go to the emergency room or hospital**  Date:

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| --- | --- | --- | --- |
| **Name and Dose of Your Medicine** | **This Medicine** **is for****my\_\_\_\_\_\_\_\_\_\_\_\_** | **How Much and How Often?** | **Reminder:****When do I take it?** |
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**If you have any problems with you medicine – do not wait. Talk to your health care provider right away.**

 **Name of Primary Primary Care Provider**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**