MY MEDICINE SCHEDULE

My Name: _____ My Phone Number: _____

Doctor Name: _____ Office Number for Refills: _____

Pharmacy Name: _____ Phone Number: _____

DRUG NAME	PURPOSE	AMOUNT of Tab/Liquid	HOW PRESCRIBED	WHEN TO TAKE (add time of medicines)					TOTAL DAILY DOSE

ALLERGIES: _____

DEVICE Type: _____ Model: _____ Serial#: _____ Date Implanted: _____

Date Completed: _____