UNIVERSAL MEDICATION FORM

Name:	**Birth Date:**	**Date list updated:**
Allergies: ☐ **None**		

1. Please start with medications for your major problems such as, (diabetes, high blood pressure, heart, cholesterol, seizures, etc.) **Write names of medications as they appear on the bottle.**
2. TRY TO LIST ALL MEDICATIONS OF ONE DISEASE (LIKE DIABETES) TOGETHER.
3. In the last 1 or 2 lines, please write your over-the-counter supplements/ vitamins/ herbs in single lines.

MEDICATION	DOSE	DIRECTIONS	REASON	DOCTOR
Example: Metformin	500mg	1 tab, twice a day	Diabetes	Dr. Example