

Medication Tracker

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Contact Number: _____

Allergies/Reactions:

MEDICATION SCHEDULE

Date: _____ dd / mm / yyyy Medication Name: _____

Dosage: _____ Time: _____

Taken (✓/✗)

☐ ✓ ☐ ✗

Side Effects/ Notes

PRESCRIBING DOCTOR

Name: _____ Contact: _____

PHARMACY INFORMATION

Name: _____ Phone: _____

INSTRUCTIONS

Write the name of each medication you take, including prescriptions, over-the-counter drugs, and supplements.

Record the dosage of the medication.

Note the time you are supposed to take each medication.

Mark ✓ if you have taken the medication, or ✗ if you have missed it.

Use the 'Side Effects/Notes' column to record any reactions or important information about the medication.

ADDITIONAL NOTES

Additional Notes

Disclaimer: This template is for personal tracking purposes only and is not a substitute for professional medical advice. Always consult with a healthcare provider for medication management and treatment decisions.