

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: _____