MEDICATION SCHEDULE

PERSONAL DATA

Patient's first name and name: ______________________________

Date of birth: ______________________________

Medication list was filled in by:

☐ Patient ☐ Family/representative ☐ General practitioner ☐ Pharmacist ☐ Home and care centre ☐ Home nursing ☐ Others: ______________

On (date): ________ / ________ / ________

CONTACTS

Contact's name: ______________________________ Telephone: ______________

☐ Patient ☐ Other: ______________________ (relation, e.g. husband, sister, etc.)

General practitioner's name: ______________________________ Telephone: ______________

Pharmacist's name: ______________________________ Telephone: ______________

PLEASE FILL IN, OR ASK SOMEONE ELSE TO FILL IN, THE MEDICATION SCHEDULE ON THE BACK OF THIS DOCUMENT AS COMPLETELY AS POSSIBLE.

Don't forget to mention:

- Blood thinners, sleeping pills, painkillers, cortisone, hormonal preparations, medication for gastrointestinal problems, insulin, antibiotics, vitamins, food supplements, medicinal herbs, homoeopathic medicines, etc.
- Ear drops, eye drops, medicinal patches, inhalers, injections, ointments, etc.
- Medicines which you use only once a week, once a year or only when needed
- Recently stopped medication (< 2 weeks)

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January 2024

MY MEDICINES							BREAKFAST			10 am	LUNCH			4 pm	SUPPER			8 pm	BEFORE GOING TO BED
Medicine	Dose	Form	Frequency	Intake	Unit	Fasting	Before	During	After		Before	During	After		Before	During	After		
E.g. Dafalgan	500 mg	effervescent tablet	2x/day	oral	tablet			1								1			

COMMENTS List all allergies or adverse drug reactions here