Healthy Weight For Life

Medication Recording Log

Patient Information

Name: _____ Gender: M / F

DOB: (dd/mm/yy) _____ Phone: _____

Address: _____

GP Name: _____ GP Phone: _____

Pharmacy Information

Name: _____

Address: _____

_____

Phone: _____

Prescription and Over-The-Counter (eg. vitamins, pain killers) **Medication Details**							
Brand name as it appears on the label	**Active ingredient/s**	**Strength**	**Dose form** (eg, tablet, capsule, syrup)	**Prescriber's name** (eg. GP, specialist, pharmacist, self-prescribed).	**Directions for use** (including daily dose breakdown – eg. breakfast, lunch, dinner, bedtime)	**Indication / reason for use**	**I miss taking this medication** 1 = once a day; 2 = more than once a week, but less than once a day; 3 = once a week; 4 = once a month 5 = rarely; 6 = never

Photocopy this page as required