Medication Schedule

Every medicine, what it is for, and when it is taken. One medicine per row. Fill it in pencil.

Name		**Birth date**	
Allergies		**Last updated**	
Pharmacy and phone		**Doctor(s)**	

Medicine and strength	What it is for	How much	Morning	Noon	Evening	Bed-time	Notes (with food? refill date)

Put a check mark under each time of day the medicine is taken. Include creams, patches, drops, inhalers and injections. Copy the name and strength exactly as they appear on the pharmacy label.

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Medication Schedule (page 2)

As-needed medicines, over-the-counter products and supplements

Product	What it is for	How much, and how often	Most in one day

Pain relievers, sleep aids, allergy pills, antacids, vitamins and herbal products all count. Many interact with prescriptions.

Stopped medicines (do not restart)

Medicine	Stopped on	Why	Who said so

Ask the pharmacist (it's free, and it takes ten minutes)

Bring every bottle, patch and supplement in a bag. Ask for a full review, and tick each question as you go.

- ☐ Is each medicine still needed?
- ☐ Do any of them interact?
- ☐ Could any cause dizziness, confusion or falls?
- ☐ Can any be taken at the same time, to cut down the number of times a day?
- ☐ Is it safe to crush or split any of them?
- ☐ Which ones must be taken with food, and which on an empty stomach?
- ☐ What do we do if a dose is missed?
- ☐ Can refills be synchronized, or pills packed by time of day?

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Weekly Check-Off Chart (page 3)

Make copies of this page, one for each week. Write the medicines due at each time, then tick each day as the dose is taken. A pill organizer can be filled once a week from this chart.

Week starting		Organizer filled by	

Time	Medicines due	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning								
Noon								
Evening								
Bedtime								
As needed								

Missed or changed doses this week

Tell the doctor or pharmacist about any pattern of missed doses. Do not stop, skip or double a medicine without asking them first.

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