DIABETESCLINIC www.diabetesclinic.ca

Clip & Keep Patient Information

Medication Diary

Your name:______________ Address:________________________________ Phone number:____________

Drug allergies:___________________ Doctor's name:______________ Doctor's phone number:___________

Include all prescription and non-prescription medications, over the counter drugs, and supplements

Drug name:____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________	**Drug name:**____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________
Drug name:____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________	**Drug name:**____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________
Drug name:____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________	**Drug name:**____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________
Drug name:____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________	**Drug name:**____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________
Drug name:____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________	**Drug name:**____________ **Dose:**____________ **When taken:**____________ **Reason prescribed:**____________ **Notes:**____________