National Multiple Sclerosis Society

REVIEW OF REGULAR MEDICATIONS

Prescription drugs

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Special directions (e.g., with food) and cautions (e.g., no alcohol): ____________________
____
____
Reason: ____
Prescribed by (name of doctor): ____________________________________
From (pharmacy): ____________________ Refills (circle) 1 2 3 4 5 6 New refill needed ☐
Issues to discuss at my next appointment: ______________________________

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Special directions (e.g., with food) and cautions (e.g., no alcohol): ____________________
____
____
Reason: ____
Prescribed by (name of doctor): ____________________________________
From (pharmacy): ____________________ Refills (circle) 1 2 3 4 5 6 New refill needed ☐
Issues to discuss at my next appointment: ______________________________

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Special directions (e.g., with food) and cautions (e.g., no alcohol): ____________________
____
____
Reason: ____
Prescribed by (name of doctor): ____________________________________
From (pharmacy): ____________________ Refills (circle) 1 2 3 4 5 6 New refill needed ☐
Issues to discuss at my next appointment: ______________________________

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REVIEW OF REGULAR MEDICATIONS

Over-the-counter medicines (non-prescription)

Name: ______________________ **Strength:**__________ **(mg, mcg, etc.)**
Frequency/Times of day: ______________ Date began: ______________
Reason: ____
____
Suggested by: ______________________________ ☐ Informed my physician

Name: ______________________ **Strength:**__________ **(mg, mcg, etc.)**
Frequency/Times of day: ______________ Date began: ______________
Reason: ____
____
Suggested by: ______________________________ ☐ Informed my physician

Name: ______________________ **Strength:**__________ **(mg, mcg, etc.)**
Frequency/Times of day: ______________ Date began: ______________
Reason: ____
____
Suggested by: ______________________________ ☐ Informed my physician

Name: ______________________ **Strength:**__________ **(mg, mcg, etc.)**
Frequency/Times of day: ______________ Date began: ______________
Reason: ____
____
Suggested by: ______________________________ ☐ Informed my physician

Name: ______________________ **Strength:**__________ **(mg, mcg, etc.)**
Frequency/Times of day: ______________ Date began: ______________
Reason: ____
____
Suggested by: ______________________________ ☐ Informed my physician

National Multiple Sclerosis Society

REVIEW OF REGULAR MEDICATIONS

Vitamins, herbs, dietary supplements

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Reason: ____
____
Suggested by: ____ ☐ Informed my physician

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Reason: ____
____
Suggested by: ____ ☐ Informed my physician

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Reason: ____
____
Suggested by: ____ ☐ Informed my physician

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Reason: ____
____
Suggested by: ____ ☐ Informed my physician

Name: ______________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day: ____________________ Date began: ____________________
Reason: ____
____
Suggested by: ____ ☐ Informed my physician