Middlesex DUIL Program

Prescription Medications and Over the Counter (OTC) Medicines

Your Name: _____

Please list all allergies (food, medicines and any other.)

On the chart below, please record the name of each medication you are currently taking, the dosage and frequency, and any special instructions (e.g., with food, before meals, etc.)

For each medication, place a check mark under the time(s) you wish to take it that is closest to the time you normally take it.

Medication	7:00 AM	Noon	5:00 PM	10:00 PM
(example) **Atenolol, 20 mg 1 tab, 2 times a day**	√			√

Medication List (cont.)

Your Name: _____

Medication	7:00 AM	Noon	5:00 PM	10:00 PM