MEDICATION SCHEDULE

PERSONAL DETAILS

First name and surname of patient: _____

Date of birth or adrema number: _____

Medication list was filled in by:

☐ Yourself ☐ Family/representative ☐ Doctor ☐ Pharmacist ☐ Residential care ☐ Home care ☐ Others: _____

On the date: _____/_____/_____

CONTACT PERSONS

Name of contact person: _____ Telephone: _____

☐ Patient ☐ Others: _____(relationship, e.g. spouse, sister, etc.) Name of your doctor: _____ Telephone: _____

Name of your pharmacist: _____ Telephone: _____

PLEASE FILL OUT OR COMPLETE THE MEDICATION SCHEDULE ON THE BACK OF THIS DOCUMENT TO THE BEST OF YOUR ABILITY.

Take the following into account as well:

- Blood thinners, sleeping pills, painkillers, cortisone, hormonal preparations, medication for stomach complaints, insulin, antibiotics, vitamins, nutritional supplements, medicinal herbs, homoeopathic remedies, etc.
- Ear drops, eye drops, medication patches, inhalers, syringes, ointments, etc.
- Medication that you use only once per week, once per year or only when necessary
- Recently discontinued medication (if you stopped using it less than 2 weeks ago)

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MY MEDICATION							BREAKFAST			10.00 AM	LUNCH			4.00 PM	DINNER			8.00 PM	BEFORE GOING TO SLEEP
Medication	Dose	Type	Frequency	Method of administration	Unit	Empty stomach	Before	During	After		Before	During	After		Before	During	After		
Example: Dafalgan	500 mg	effervescent tablet	2x per day	orally	tablet			1								1			

COMMENTS Record any allergies or side effects of medicines here