

Mind your MEDS



Make a copy of this chart for each medication that you take.

Medication: _____

For: _____

Dosage: _____

Refill date: _____

Doctor's name and phone number: _____

Pharmacy name and phone number: _____

Example

TIME	SUN.	MON.	TUE.	WED.	THU.	FRI.	SAT.	NOTES
Morning	X	X	X	X	X	X	X	Feel great after a full week of UC meds.

Week # _____

TIME	SUN.	MON.	TUE.	WED.	THU.	FRI.	SAT.	NOTES
Morning								
Afternoon								
Evening								
Night								

Week # _____

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Afternoon								
Evening								
Night								

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