AMERICAN LUNG ASSOCIATION®

MEDICATION **TRACKER**

Pharmacy Information

Name of Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Work with your care team to fill in the log below:

Remember to cross out any medications you are no longer taking!

Name of medication	What is this medication for?	Date Prescribed	Doctor that prescribed medication	How much? (dose)	How often?	Directions for taking medication	Side Effects

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