DK Law

MEDICATION LOG

Personal Record Document

Name: _____ Injury/Accident Date: _____ Page ____ of ____

Prescription Medications

Start Date	Stop Date	Medication Name	Dosage	Frequency	Prescribing Doctor	Reason / Injury Treated	Cost per Fill ($)

Over-the-Counter

(pain relievers, sleep aids, creams, braces, etc.)

Date Purchased	Item	Reason	Where Purchased	Cost ($)

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SIDE EFFECTS TRACKER

Personal Record Document

Medication: _____

Side Effects Experienced:

How it affected daily life (work, sleep, driving, mood):

Date Started: _____ **Date Reported to Doctor:** _____

Doctor's Response / Action Taken: _____

Medication: _____

Side Effects Experienced:

How it affected daily life (work, sleep, driving, mood):

Date Started: _____ **Date Reported to Doctor:** _____

Doctor's Response / Action Taken: _____

Medication: _____

Side Effects Experienced:

How it affected daily life (work, sleep, driving, mood):

Date Started: _____ **Date Reported to Doctor:** _____

Doctor's Response / Action Taken: _____

Refill & Copay Record

Date	Medication	Pharmacy	Amount Paid ($)