Multiple Sclerosis Society of Canada

Prescription Drugs

Name:__________________________________ **Strength:**____________ **(mg, mcg, etc.)**
Frequency/Times of day:______________________ Date began:________________________
Special directions (e.g., with food) and cautions (e.g., no alcohol): ______________________
____
____
Reason:____
Prescribed by (name of doctor):____
From (pharmacy):____________________ Refills (circle): 1 2 3 4 5 6 *Need new refill
Issues to discuss at my next appointment: ____
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Over-the-counter medicines (Non-prescription)

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Vitamins, herbals, dietary supplements

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