DAILY MEDICATION

Journal

Week of (date)

Weekday	Medication	Time	Dose	With Food Circle Y / N	Side Effects	Time Noticed	Notes
Monday				Y N Y N Y N Y N			
Tuesday				Y N Y N Y N Y N			
Wednesday				Y N Y N Y N Y N			
Thursday				Y N Y N Y N Y N			
Friday				Y N Y N Y N Y N			
Saturday				Y N Y N Y N Y N			
Sunday				Y N Y N Y N Y N			

Be sure to include any medications including OTC, prescription, vitamins and supplements.

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DAILY SYMPTOMS

Week of (date)

Medications/therapies

Activities affected

Able to work? Give details.

Symptoms and how you're feeling

Duration/frequency

Insurance communications and medical treatments

(organization name, name of person, what they said, duration of visit/conversation)

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