Flashpoint Acupuncture

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My Medicine Record

Name:_____ **Date**_____

— Enter ALL prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine, and dietary supplements —

What I'm Using Rx – Ex Brand & generic name; OTC – Name & active ingredients	**Why I'm Using / Notes** Ex: Lowers blood pressure; check blood pressure	**How Much** Ex: 40 mg; use two 20 mg pills	**How to Use / When to Use** Take orally, 2 times a day, at 8:00 am & 8:00pm	**Start / Stop Dates**	**Who Told Me to Use / How to Contact** Doctor name