

































# My Easy Drug System™ (MEDS) Chart

Name: \_\_\_\_\_  
Date: \_\_\_\_\_  
Primary Doctor: \_\_\_\_\_  
Any Allergies? \_\_\_\_\_

Which medications matter most to you?

Drug name	Why I take this	How do I feel about it?	Notes
		  	
		  	
		  	
		  	
		  	
		  	
		  	
		  	
		  	
		  	



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