Medication List

Pulmonary Hypertension Association
Empowered by hope

Name: _____ **Phone:** _____

Medication Name (as listed on package or bottle)	**Dosage and Frequency** (Strength, amount, how many times a day)	**Prescribed by** (Physician Name)	**Medication Type (Infused, inhaled or pill)** If pill, list size and color.	**Medical Condition it Treats**	**My Side Effects**

Test Results

Name: _____ Phone: _____

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Date	Hospital	Physician Name	Procedure/Test	Results