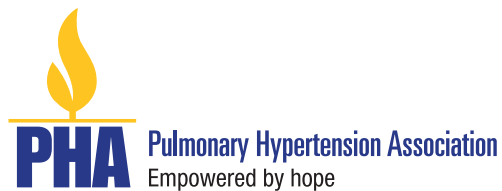


Medication List



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



Pulmonary Hypertension Association

Empowered by hope

Name: _____ **Phone:** _____

[illegible]