PRESCRIPTION SIDE EFFECTS JOURNAL

Month/Year: _____

MEDICATION NAME & DOSAGE

START DATE

PRESCRIBING DOCTOR

DATE / TIME	SIDE EFFECT DESCRIPTION	SEVERITY (1-10)	DURATION	TRIGGERS OR NOTES (FOOD, SLEEP, STRESS)

DATE / TIME	SIDE EFFECT DESCRIPTION	SEVERITY (1-10)	DURATION	TRIGGERS OR NOTES (FOOD, SLEEP, STRESS)

Note: 1 = Minimal/Barely Noticeable | 5 = Moderate/Affects Daily Tasks | 10 = Severe/Requires Medical Attention