

WEEKLY MEDICATION ASSESSMENT

Week of: _____

Medication Name & Dosage: _____

Patient Name: _____

**Side Effect /
Symptom**

Mon

Tue

Wed

Thu

Fri

Sat

Sun

Nausea / Upset
Stomach

Dizziness /
Lightheadedness

Fatigue /
Drowsiness

Headache

Dry Mouth

Appetite Changes

Sleep Pattern
Changes

Mood Changes /
Anxiety

**Side Effect /
Symptom**

Mon

Tue

Wed

Thu

Fri

Sat

Sun

Other:

Severity Scale: 0 = None 1 = Mild (Noticeable) 2 = Moderate (Interferes with tasks) 3 = Severe (Incapacitating)

This chart is for personal tracking. Consult a medical professional for clinical diagnosis.