ARTHRITIS MEDICATION TRACKER

Month/Year: _____

Patient Name: _____
Primary Physician: _____

DATE	MEDICATION & DOSAGE	TIME	PAIN LEVEL (1-10)	STIFFNESS (AM/PM)	NOTES / SIDE EFFECTS

DATE	MEDICATION & DOSAGE	TIME	PAIN LEVEL (1-10)	STIFFNESS (AM/PM)	NOTES / SIDE EFFECTS

** Pain Scale: 1 (Minimal) to 10 (Severe). Note any specific joints affected in the Notes column.*

Physician Discussion Points: