My Medication List

Patient Name: _____DOB: _____Allergies:_____

List all medicine you are currently taking: Prescription and over -the-counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Medication (Brand & Generic Name)	Dose	How often you take the medication?	Reason for taking	Date Started	Prescriber

Do you give us permission to call your pharmacy for a medication list? Y/N _____Patient Sig:_____