CURRENT MEDICATION LIST:

Prescription and Over-the-Counter
(Vitamins, Herbal Supplements, etc.)

Date: ______________________________

Name: ______________________________

Primary Doctor: ______________ Primary Doctor Phone#: ______________

Medication Allergies: ______________________________

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Other Allergies: ______________________________

Are you allergic to Latex?		Yes		No	If yes, reaction:

Name of Medication	Dosage	Times Per Day	Route taken (Oral, injection, etc.)	Reason for taking	Prescribing Doctor	Date Started

Rev 1/25/17

Physician's Signature:______________________________