

Please list all medications that you are currently taking.
Include all over-the-counter medicines, vitamins and herbal supplements.
Please PRINT as clearly as possible.

Patient Name: _____ Date of Birth: _____

Allergies: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Please bring all the medication bottles with you to your appointment so we can do a thorough review of your medications.

Name of Medication Brand or Generic Name	Strength/Dosage mg, units, puffs or drops	Directions How many times per day? Only as needed?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____