OHC
SPECIALISTS IN CANCER
AND BLOOD DISORDERS

PATIENT LIST OF MEDICATIONS

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: _____

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.		

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