

Name: _____

DOB: _____

Date: _____



List of Current Medications

If you have a separate list of your medication, please bring the printed list to your appointment. Skip and go to the next page.

List all **prescription** medications FIRST, then all tablets, patches, drops, ointments, injections, etc.

Also list any medication you take only on occasion (like Viagra, Albuterol, Nitroglycerin).

Medication (Brand & Generic Name)	Dose	Reason for taking Medication	How often do you take this medication	How do you take this medication	Start Date (mm/dd/yyyy)	Prescriber
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		
				<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical		

Over the Counter Products: Vitamins Over the Counter Pain Relievers Diet Supplements Herbal

