

**MEDICATION LIST**

Allergic to \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ DOB \_\_\_\_\_

Name of Med.	Strength	Dosage	Dr. Prescribing
--------------	----------	--------	-----------------

- |     |       |       |       |
|-----|-------|-------|-------|
| 1.  | _____ | _____ | _____ |
| 2.  | _____ | _____ | _____ |
| 3.  | _____ | _____ | _____ |
| 4.  | _____ | _____ | _____ |
| 5.  | _____ | _____ | _____ |
| 6.  | _____ | _____ | _____ |
| 7.  | _____ | _____ | _____ |
| 8.  | _____ | _____ | _____ |
| 9.  | _____ | _____ | _____ |
| 10. | _____ | _____ | _____ |
| 11. | _____ | _____ | _____ |
| 12. | _____ | _____ | _____ |
| 13. | _____ | _____ | _____ |

**Over-The-Counter Medications- Include any taking regularly**

Name	Strength	Dose Taking
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- |    |       |       |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

*Medications Page 2*

<i>Name</i>			<i>Date</i>
Name of Med	Strength	Dosage	Dr. Prescribing

14. \_\_\_\_\_

15. \_\_\_\_\_

16. \_\_\_\_\_

17. \_\_\_\_\_

18. \_\_\_\_\_

19. \_\_\_\_\_

20. \_\_\_\_\_

21. \_\_\_\_\_

22. \_\_\_\_\_

23. \_\_\_\_\_

24. \_\_\_\_\_

25. \_\_\_\_\_

26. \_\_\_\_\_

27. \_\_\_\_\_

28. \_\_\_\_\_

29. \_\_\_\_\_

30. \_\_\_\_\_

31. \_\_\_\_\_

32. \_\_\_\_\_

33. \_\_\_\_\_

