

The medicines you take are a very important part of your health information. Please fill out this medication list (or have your caregiver complete) and discuss with your medical provider. If you need more space to write out your medicines, copy this form or use a blank piece of paper.

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CURRENT MEDICATIONS			PROVIDER COMMENTS
PRESCRIPTION DRUG NAME	STRENGTH / DOSE	DIRECTIONS	

OVER THE COUNTER MEDICATIONS	STRENGTH / DOSE	DIRECTIONS

HERBAL, VITAMINS, MINERALS, COMPLIMENTARY PRODUCTS	STRENGTH / DOSE	DIRECTIONS

PHARMACY NAME / LOCATION / PHONE #:	
ALLERGIES	TYPE OF REACTION
Do you react to latex or rubber (gloves, paint, condoms, balloons) with a rash, watery eyes, or wheezing? Y / N	
If yes, please explain: _____	
Clinical Staff Review:	Initials / Date:

IMPRINT PATIENT INFORMATION:



WHITE – PHARMACY
YELLOW – CLINICAL NURSE
COORDINATOR

MED004 (4/05)

MEDICATION LIST