Current Medication List

***Please fill this form out completely*.**

The doctor will need to review all your medications each time you are in our office.

You may be asked to complete this form more than one time during the year.
It is very important that our doctors have an updated list of all your medications at all times.

Patient's Name _____ Date of Birth_____

Today's Date _____

If there is ever a change in your medications let us know as soon as possible.

List ALL medications you are currently taking (prescriptions, over the counter, vitamins, minerals, etc.)

Name of Medication	Strength	How many times a day do you take this medication?	How long have you been taking this medication?	Name of doctor who prescribed this medication.

Do you have an allergy to any drugs?

Please list ALL prescriptions, over the counter, etc. drugs you are allergic to.
