Patient Medication List

For your safety, please list all medications, vitamin or herbal supplements, or over-the-counter remedies that you are currently taking. Also, please inform us of any changes to any items previously listed. Thank you.

Patient Name:_____ **Date Completed:**____/____/_____

Date of Birth:____/____/____

Preferred Pharmacy #1) _____ Ph# _____

Preferred Pharmacy #2) _____ Ph# _____

Name of Medication	Dosage	Reason for taking	Start Date	End Date

Revised 08/13/2014