PATIENT MEDICATION LIST

ACCOUNT #	**ALLERGIES / REACTION** (IF A LONG LIST, PLEASE BRING A COPY)
PATIENT NAME:	
DOB:	

	Prescription Medication, Supplements, and Herbal Remedies and Dosage	Frequency	Last dose		Prescription Medication, Supplements, and Herbal Remedies and Dosage	Frequency	Last dose
1				21			
2				22			
3				23			
4				24			
5				25			
6				26			
7				27			
8				28			
9				29			
10				30			
11				31			
12				32			
13				33			
14				34			
15				35			
16				36			
17				37			
18				38			
19				39			
20				40			

ARE YOU TAKING A BLOOD THINNER? YES OR NO

IF YES, WHICH MEDICATION? _____

Patient Signature: _____ Date: _____

PROVIDER SIGN OFF

DATE	INITAL	DATE	INITAL