MY MEDICATION LIST

Patient Name: _____ Date: _____

Date of Birth: _____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. ***Bring this list with you to your first appointment.***

Drug Name	Drug Strength	Amount and Times of Day Taken	Reason for Medication	Prescriber

Do you have any allergies? _____ Yes _____No

If yes, please list:

_____

_____