MEDICATION FORM

TODAY'S DATE: ____________________

Name:	Address:
Phone Number:	Medication Allergies:
Birth Date:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin). Use back of form if necessary.

DATE STARTED	NAME OF MEDICATION / DOSE	DIRECTIONS: (How many times a day do you take this and when?)	Notes: Reason for taking / Doctor Name (If the same doctor prescribed all of your meds only list his/her name on first line.

Patient Signature: ______________________________ Date: ______________

Responsible Adult Signature (if applicable): ______________________________ Date: ______________