Current Medication List

Please complete all fields, save this file, and email it back to us — or print and bring it to your visit.

PATIENT INFORMATION

Patient Name	Today's Date	Date of Birth

ALLERGIES & REACTIONS

List any medication allergies and the reaction you experienced. Write "NKDA" if none known.

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CURRENT MEDICATIONS

Include prescription medications, over-the-counter medications, and supplements. One line each: medication name — dosage — frequency — prescribing doctor.

	Medication	Dosage	Frequency	Prescribing Doctor
1				
2				
3				
4				
5				
6				
7				

Medication 8	Dosage	Frequency	Prescribing Doctor

Medication 9	Dosage	Frequency	Prescribing Doctor

Medication 10	Dosage	Frequency	Prescribing Doctor

PHARMACY

Pharmacy Name	Pharmacy Phone

Patient Signature (type full name)	Date