MEDICATION LIST

PATIENT NAME: _____ DATE OF BIRTH:_____

Name of Medication	Dose you take (mg, units, puffs/drops)	When you take it? How many times a day? Morning and night? After meals? With meals?

Drug Allergies: _____

Please be aware that you are able to have your prescriptions filled here or elsewhere.

Pharmacy Name/Address: _____

Pharmacy Phone Number: _____

Patient Signature: _____ Date: _____