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Patient Name:_____

Pharmacy Name & Address:

_____

_____

Help us care for you better by telling us what prescriptions, over-the-counter medications, vitamins, supplements, or diet aids you take. We will update this every time you visit.

Medications, vitamins, supplements, etc.			
Name of Medicine	**Dose**	**How many times per day?**	**Who prescribed it? (Physician's Name)**

Medication Allergies	
Name of Medication	**Allergy (reaction they cause)**

Reviewed by:	**Date Updated**

Revised 5/24/07