

CURRENT MEDICATIONS

PLEASE COMPLETE ONLY THE SHADED AREAS

PATIENT NAME: _____

It is important that you record below **all** medications you are taking:

NAME OF MEDICATION	HOW MUCH / HOW OFTEN	FOR WHAT MEDICAL CONDITION ARE YOU TAKING THIS?	
Example:	Inderal	20 mg 3 times a day	High Blood Pressure
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

PHARMACY INFORMATION:

Name: _____ City: _____ Phone: _____

Date Initiated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____

Date Updated: _____