Medication List

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Allergies: _____

Pharmacy Name and Address: _____

Pharmacy Telephone Number: _____ Pharmacy Fax Number: _____

Please list all prescription medicines, inhalers, oral chemotherapy, hormonal agents, over-the-counter medicines (such as aspirin, Tylenol®, Maalox®), vitamins, herbals, supplements, and alternative therapies that you take. **Be sure to bring in all bottles for each appointment.**

Name	Dose (mg, g, ml)	How Often (twice a day, every 8 hours)	Route (injection, by mouth)	Date When Started	Date Stopped

Name	Dose (mg, g, ml)	How Often (twice a day, every 8 hours)	Route (injection, by mouth)	Date When Started	Date Stopped