

# MEDICATION LIST

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Active Medications** (including non prescription)                      **Dose**                      **Prescribing Physician**

- |     |       |       |       |
|-----|-------|-------|-------|
| 1.  | _____ | _____ | _____ |
| 2.  | _____ | _____ | _____ |
| 3.  | _____ | _____ | _____ |
| 4.  | _____ | _____ | _____ |
| 5.  | _____ | _____ | _____ |
| 6.  | _____ | _____ | _____ |
| 7.  | _____ | _____ | _____ |
| 8.  | _____ | _____ | _____ |
| 9.  | _____ | _____ | _____ |
| 10. | _____ | _____ | _____ |
| 11. | _____ | _____ | _____ |
| 12. | _____ | _____ | _____ |
| 13. | _____ | _____ | _____ |
| 14. | _____ | _____ | _____ |
| 15. | _____ | _____ | _____ |
| 16. | _____ | _____ | _____ |
| 17. | _____ | _____ | _____ |
| 18. | _____ | _____ | _____ |
| 19. | _____ | _____ | _____ |
| 20. | _____ | _____ | _____ |

**Medication Allergies**

- |    |       |    |       |
|----|-------|----|-------|
| 1. | _____ | 4. | _____ |
| 2. | _____ | 5. | _____ |
| 3. | _____ | 6. | _____ |

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_