# Patient Medication List

For your safety, please list all medications, vitamin or herbal supplements, or over-the-counter remedies that you are currently taking. Also, please inform us of any changes to any items previously listed. Thank you.

**Patient Name:**_____ **Date Completed:**____/____/_____

**Date of Birth:**____/____/____

Preferred Pharmacy #1) _____ Ph# _____

Preferred Pharmacy #2) _____ Ph# _____

| Name of Medication | Dosage | Reason for taking | Start Date | End Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Revised 08/13/2014