Patient Name: _____ Encounter Date: _____/_____/_____
DOB: _____/_____/_____

Medication Record

It is important to our physicians that each of our patients update medications at each visit in order to prevent drug interactions, ensure patient safety and deliver quality care. We kindly ask all patients to list all medications. Always include over-the-counter, herbals and vitamins/mineral/dietary supplements. Please also list your drug allergies on the line below.

The clinical assistant will use the shaded area to review your medications with you for the next seven visits.

Drug Allergies: _____

				Shaded Area for Office Use Only						
			Appointment Date:							
Medications (Prescription, Over-the-Counters, Herbals, Vitamin/Mineral/Dietary Supplements)	Dose	Frequency (Ex. 2x/Day)	Route (Ex. Injection, By Mouth, Patch, etc.)	Is the patient currently taking these medications? (Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)