Medication Record

Patients name: _____**DOB**: _____

Current Prescription Medications

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Over the Counter Medications, Herbal therapies and Supplements

1._____

2. _____

3. _____

4._____

5. _____

6. _____

Are there any medications that you are currently taking that you are having difficulty taking or experiencing side effects?

_____

Medication allergies and reaction

_____

Current Pharmacy and location

_____