Patient Medication Record

Date: _____

Name_____

Phone Number _____

Address_____

_____

Date of Birth_____

Primary Care Physician _____

Allergies	Describe Reaction

List all prescription, over the counter (non-prescription) medications and herbal supplements. Also include any medications which are only taken as needed.

Start Date	Name of Medication (Brand and Generic if available)	Dose (mg, units, puffs, drops, etc)	When /How often do you take this medication?	Purpose	Ordering Physician	Date Stopped taking medication or discontinued	Do any of the medications require special monitoring? (lab testing, frequency, etc)