MEDICATION LIST

DATE: _____

NAME: _____ DOB: _____

What **PRESCRIPTION** medication are you taking at this time?

Name of Medication Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What **OVER THE COUNTER** medications are you taking? (Aspirin, Motrin, Vitamins, etc..)

Name of Medication Dosage Frequency

_____

_____

_____

MEDICATION ALLERGIES

Please list the medications and injections that have given you a bad reaction. If possible include your reactions (hives, welts, rash, itching, headaches, nausea, diarrhea, shortness of breath etc)

_____

_____

_____