Patient Medication List

Patient Name:_____ Date of Birth:_____

Procedure Date:_____ MD:_____ Primary Care MD:_____

It is important for your physicians to have an **up to date record of all the medication you take.** Please use this form to list all the medications you take on a regular basis (including herbals, over the counter medications and vitamins). Copy the information from the medication container, including the dose and how often you take it (example: 50mg 4x/day).

PLEASE BRING THIS LIST WITH YOU ON THE DAY OF YOUR PROCEDURE.

DO NOT BRING THE MEDICATION WITH YOU.

Pharmacy Name & Phone Number:_____

Medication Allergies:_____

CURRENT MEDICATIONS Including regularly taken OTC, Herbals, etc.)	Dose	Frequency	Taken day of procedure? YES / NO

Continue on reverse if necessary