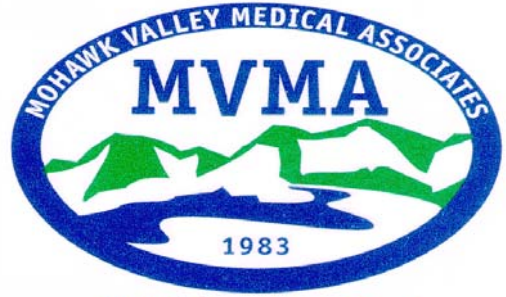


## MEDICATION LIST

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Primary Care Physician \_\_\_\_\_



*Physicians Committed  
to Quality*

Allergies to Medications	Medication	What happened? (Rash, upset stomach, trouble breathing, etc)

Prescription Medications	Medication	Who Prescribed it?	Dose	How Often	

Over the Counter Medications Including Vitamins	Medication/Vitamin	Dose	How Often	

Herbs, Dietary Supplements, Homeopathic Remedies	Product Name	Dose	How Often	

**Please copy all your meds, vitamins, etc. onto the form below. Keep this summary with you in case of emergency:**

Cut here ----- Cut here

Medication	Dose	Medication	Dose	Medication	Dose
1		7		13	
2		8		14	
3		9		15	
4		10		16	
5		11		17	
6		12		18	