

## HOME MEDICATION LIST

Please bring a complete list of your home medications with you for your initial appointment so we can review your current medications with you.

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

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

<b>List Medication Allergies:</b>	<input type="checkbox"/> <b>Please check here if you do not have any medication allergies.</b>		
<input type="checkbox"/> <b>Please check here if you do not take any medications at home</b>			
<b>Medication Name</b> <i>Include over the counter medications and herbal preparations</i>	<b>Dose</b> (How much)	<b>How do you take it?</b> (by mouth, patch, injection, inhaler, ointment, drops)	<b>Frequency</b> (How often)
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**OVER =>**

### PAST MEDICATIONS:

Please do your best to recall any medications and/or supplements that you have taken in the past. If you cannot remember dosages, please put the item down anyway. What is most important is that we have a record of what you *have* taken. Please be as detailed as possible.

**Please check here if you have never taken any medications**

<b>Medication Name</b> <i>Include over the counter medications and herbal preparations</i>	<b>Dose</b> (How much)	<b>How do you take it?</b> (by mouth, patch, injection, inhaler, ointment, drops)	<b>Frequency</b> (How often)
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