MEDICATION LIST

Please COMPLETELY fill out all information for all medications you are currently taking: Date a column, place a '√' beside each medication, and initial at the bottom.
*****At follow up visits: Please date a new column, place a '√' beside each medication that has not changed and place an 'x' in the column if you have discontinued a medication. Add any new medications to the list and initial at the bottom.**

Name:_____ **DOB:** _____ **Date:**_____

Pharmacy:_____ **Pharmacy #:**_____

			Date at top and '√' or 'x' beside each medication:								
MEDICATION:	**STRENGTH:**	**DIRECTIONS:**	1/1/16								
Example: Prilosec	10 mg	Once Daily	√								
		INITIAL:									

DRUG ALLERGIES:

☐ I have no drug allergies.

Name:	**Reaction:**
1.	
2.	
3.	
4.	
5.	

Patient Signature: _____ **Date:** _____

RENA AZAR, MD