

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