CURRENT MEDICATION LIST

Please note: If you have a list with you, please alert the front desk before filling out this form.

Patient name: _____ **Date of birth:** _____ Height:_____ Weight:_____

Name of Medication	Dose/Strength	How often taken

DRUG ALLERGIES: **NO KNOWN DRUG ALLERGIES**

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Preferred pharmacy: _____

May we contact your pharmacy to obtain your prescription fill history? Y or N

(Please circle)