



PATIENT MEDICATION RECORD

Patient Name: _____ Today's Date: _____

ALLERGIES:

Medication Name/Type of Reaction

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List below all of the medications that you take including over-the-counter and alternative remedies. Write if you do not know or cannot remember all of the medications that you take. Always bring a list of every medication you take to every medical appointment.

Medication Name	Dose	Route	How Often

Medication history verified with patient by: _____ Date: _____

Medication history verified with patient by: _____ Date: _____

Medication history verified with patient by: _____ Date: _____