Current List of Medications

_____ _____

PATIENT'S NAME PATIENT'S BIRTHDATE

Please list all prescribed medications, over the counter medications, dietary supplements, herbal remedies, vitamins, minerals, illegal drugs, etc.,.

Medication or other	Dosage	Frequency (ie times per day)	Route (oral, IV, drops, cream)	Last Taken

☐ Check this box if an *attached list of medications* is provided and a copy is in the chart.

☐ *Check this box if there are no medications* or other items to be mentioned.

☐ Check this box if *someone other than the patient* completed this form. Please then provide the name and signature of the person completing this form below.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

PROVIDER SIGNATURE (review only) DATE

Note: only a pharmacist and/or the prescribing physician(s) can make determinations of proper dosage, interactions, side effects, etc.,. This form is a review and has been deemed a necessary part of your intake paperwork by Medicare.