



PATIENT MEDICATION HISTORY FORM

To our patients: The medicines you take are part of your health information. Please fill out this form or have your caregiver complete it. If you need more space to list your medicines, ask for another form.

Name <small>(Last, First, M.I.):</small>			DOB:
CURRENT MEDICATIONS			
Prescription Drugs	Strength (such as 50 mg)	Directions (such as 2 tablets in the a.m.) (Check box if taken only as needed.)	Prescribed By (such as John Doe, MD)
<input type="checkbox"/> Check if none			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
Over-the-Counter Medications (such as aspirin)	Strength	Directions (such as for headaches, when needed)	
<input type="checkbox"/> Check if none			
Herbs, Vitamins, Minerals, Etc. (such as St. John's Wort)	Strength	Directions (such as one tablet each day)	
<input type="checkbox"/> Check if none			