MEDICATION LIST

PATIENT NAME ____

DATE OF BIRTH ________________ DATE ____________________

Please list all pills that you have taken over the last TWO WEEKS, with or without a prescription. Include aspirin, birth control pills, alternative therapy, health supplements, pills sold in health food stores:

NAME OF DRUG, MEDICINE OR ALTERNATIVE THERAPY	DOSE (if known)	HOW MANY PER DAY OR WEEK
1. ____________________	__________	____________
2. ____________________	__________	____________
3. ____________________	__________	____________
4. ____________________	__________	____________
5. ____________________	__________	____________
6. ____________________	__________	____________
7. ____________________	__________	____________
8. ____________________	__________	____________
9. ____________________	__________	____________
10. ____________________	__________	____________
11. ____________________	__________	____________

DOCTOR'S SIGNATURE ________________________________

A.P.R.N. SIGNATURE ________________________________