PATIENT MEDICATION FORM

PATIENT NAME:_____**DATE OF BIRTH:** _____

PHARMACY NAME: _____**ADDRESS:** _____ **PHONE:** _____

Do you consent to obtaining/importing a history of your medications purchased at pharmacies? ○ **Yes** ○ **No**

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. List any medicine you take on occasion (For example, Viagra, Tylenol, Nitroglycerin).

Medicine (Brand and generic name)	Dose	How and how often you take the medication (By mouth, under your tongue, injection, etc.)	Last Taken
Example: Baby Aspirin	81mg	By mouth 1 tablet once a day	5pm yesterday

If needed please turn to the other side.

Please refer to procedure paperwork for complete instructions regarding medications.
There are restrictions on certain medications for example, prescription blood thinners, diabetic medications, and supplements.

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