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MEDICATION LIST

Patient's Name: _____ **Date:** _____

Pharmacy Name: _____ **Phone Number:** _____-_____-_____

Pharmacy Location: _____

Please list ALL current medications (including vitamins and over the counter medication, supplements, and herbs):

NAME	DOSAGE	INSTRUCTIONS

ALLERGIES (DRUG, FOOD OR ENVIORNMENTAL)

Do you have any allergies to medications or other substances including, but not limited to environmental foods?
☐ YES ☐ NO
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

ALLERGEN	SEVERITY (VERY MILD, MILD, MODERATE, SEVERE)	REACTIONS	ONSET (CHILDHOOD, ADULT, UNKNOWN)