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Current Medication List

Patient Name:	**Date of Birth:**
Phone Number:	**Doctor at this office:**

Allergic To/Describe Reaction:	**Allergic To/Describe Reaction:**

List all prescription <u>and</u> over-the-counter (non-prescription) **medications** such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort) Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin.)

Indicate any medications that require refills with an "X"

Date Started	**Name of Medication**	**Dosage and Directions: How often? How many? Number Prescribed?**	**Need Refill? (Mark X)**	**Reason for taking**