Medication Chart for:_____

PATIENT NAME

Date of Birth:_____ **Today's Date:**_____

Please list any **allergies to medications**_____

_____

Please list any **food allergies** (peanuts, eggs, shellfish, etc.)_____

_____

Please list all current prescriptions and over-the counter medications that you are taking. Please update this list every time you come to the office.

PRESCRIPTIONS						
Name of Medication	**Dose (total mg)**	**How many times daily?**	**When do you take it? (AM, PM? After meals?)**	**Who prescribed? (Dr's last name)**	**Why do you take this medication?**	**Side effects? (Describe them)**
EXAMPLE: Macrobid	100mg	2	AM and PM	Dr. Gehring	Bladder Inf.	No
OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBAL REMEDIES						