Medication List

Preferred Pharmacy: ______________________________________
Phone Number

Allergies to medication (X-ray dyes, drugs):

____

Example:
Name of medication: Aspirin
Dose or strength of medication: 500 mg
Directions: take one by mouth daily

1. Name of medication:_____________________________
   Dose or strength of medication: ___________________
   Directions: ______________________________________
2. Name of medication: _____________________________
   Dose or strength of medication: ____________________
   Directions: ______________________________________
3. Name of medication: ______________________________
   Dose or strength of medication: ____________________
   Directions: _______________________________________
4. Name of medication: ______________________________
   Dose or strength of medication: _____________________
   Directions: _______________________________________
5. Name of medication: ______________________________
   Dose or strength of medication: _____________________
   Directions: _______________________________________

PLEASE REMEMBER TO BRING ALL OF YOUR MEDICATION BOTTLES (EVEN THOSE FROM OTHER PHYSICIANS) TO ALL OF YOUR APPOINTMENTS