Current Medications

Name:_____

Pharmacy:_____ Phone:_____

Rx Allergies/Reactions:_____

DRUG NAME	FREQUENCY/ DOSAGE	REASON TAKING	PRESCRIBING MD	DATE Rx STARTED	REACTIONS/ SIDE EFFECTS

Medications Taken in the Past

Name:_____

DRUG NAME	FREQUENCY	REASON TAKING	PRESCRIBING MD	DATE Rx STARTED/STOPPED	REASON FOR STOPPING