Patient Health History and Information
Medication List

In order to maintain optimal care, it is important for us to maintain an up-to-date list of all of your medications.

If you have a current list of your medications, we will be happy to make a copy to attach here.

Name of prescription medication	**Dosage**	**Why are you taking this medication?**	**How often do you take this medication?**	**How do you take it? (by mouth, injection, etc.)**
Example: Lasix	*20mg*	*High blood pressure*	*Two times a day*	*By mouth*
Over the counter medication or nutritional supplements	**Dosage**	**Why are you taking this medication?**	**How often do you take this medication?**	**How do you take it? (by mouth, injection, etc.)**

Print Name: _____DOB:_____ Date: _____