## **Medication List**

Patient Name:	Date of Birth:	Today's Date:
Allergies:		<u> </u>
Pharmacy Name and Address:		
Pharmacy Telephone Number:	Pharmacy Fax Number:	
Please list all prescription medicines, inhalers, oral chemo Maalox <sup>®</sup> ), vitamins, herbals, supplements, and alternative		

Name	Dose (mg, g, ml)	How Often (twice a day, every 8 hours)	Route (injection, by mouth)	Date When Started	Date Stopped

Name	Dose	How Often	Route	<b>Date When</b>	Date
	(mg, g, ml)	(twice a day, every 8 hours)	(injection, by mouth)	Started	Stopped
Office Use Only	1	1	1		•
Office Use Only:					
Initials/Date Verified:	_ Initials/Clarified: Initials/Clarified:	APN/MD Signature/Date Reconciled: APN/MD Signature/Date Reconciled:			
Initials/Date Verified:	_ Initials/Clarified:	APN/MD Signature/Date Reconciled:			
Initials/Date Verified:	Initials/Clarified:	APN/MD Signature/Date Reconciled:APN/MD Signature/Date Reconciled:			