Patient Medication List

Patient Name:____ **Date:** __________________

Instructions:

1. List everything you are **currently taking or have taken within the last 90 days**, including alcohol (beer, wine, etc), tobacco/cigarettes/chewing tobacco, street drugs, over-the-counter medications, vitamins, herbal/supplements, home remedies, anti-cancer treatments and prescription medications.
2. Bring this form and **ALL** your medication bottles with you each visit for review and updates.

Name of Medication	Year you started taking this Medication	Dose Taken	How Often	Route (by mouth, shot, etc)	Why do you take this Medication?

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For Office Use Only: STMW Protocol #: _______________