Patient Medication List

Patient Name:_____ **Date:** _____

Instructions:

1. List everything you are taking including alcohol (beer, wine, etc), tobacco/cigarettes/chewing tobacco, street drugs, over-the-counter medications, vitamins, herbal/supplements, home remedies, and prescription medications.
2. Bring this form and 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?