PATIENT'S MEDICATION HISTORY

All records are confidential unless patient authorizes release.

All Medications Taken Regularly

(Include prescriptions, vitamins, aspirin, Tylenol, nasal sprays, medicated ointments, stomach preparations, ect.)

☐ *Please check box if you are not taking any medications regularly.*

Name of Medication	Dose	Frequency Taken	Start Date	Form of Medication *See key	Condition Taking Medication for
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
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				☐ Oral ☐ Topical ☐ Other:	
				☐ Oral ☐ Topical ☐ Other:	
***KEY:**	*Oral- by mouth (pill, tablet, capsule, liquid)* *Topical- applied to skin (cream, ointment, gel, liquid, solution)* *Other- injection (sub-cutaneous, intra-muscular), nasal, inhaled, eye drops*				

Patient Name:_____ Patient DOB (mm/dd/yyyy):_____