Complete Medication List
(including Over-the-Counter,
Vitamins and Herbals)

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Patient Account#:____________Date:________________

PATIENT INFORMATION

Last Name:__________________________ **First Name:**________________________ **Middle Name:**_______________

Suffix: JR SR III IV or ______ **Nickname:**_________________________ **Date of Birth:**____/____/____

Street Address:______________________________ **City:**__________________________ **State:**___________ **Zip:**______________

Email*:______________________________________ **Home#:** (______)_______-________ **Mobile#:**(_______)_______-_________

*Your email will be used to invite you to Patient Portal access

Prescription Medication List

List all medicine you are currently taking:

Prescription Medication Name	Dose (How much) Mg: tablets or capsules, units, drops, etc.	Frequency (How often)	Route of Administration Oral, Injections, Topical, Sublingual
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □

Over-the-Counter Medications / Vitamins / Herbals

List all Over-the-Counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko).

Prescription Medication Name	Dose (How much) Mg, units, drops, etc.	Frequency (How often)	Route of Administration Oral, Injections, Topical, Sublingual
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □
	□ mg (__TAB __CAP) □__________	___x day or □ AM □ PM □ As needed	□ Oral □ Injection or □

X____ _____________________________

Signature of Patient, Parent, Guardian or Personal Representative **List Completed or Updated on Date**