

PATIENT NAME: _____

PATIENT ID: _____

PATIENT MEDICATION LIST

The nurse will review this information with you during the admissions process.

Allergies (list all allergies, including food, latex and medication and the reactions that they cause)

<u>Medication/Food/Latex Allergy</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Please complete this form, list **all** medications you currently take, including vitamins, herbal supplements, antacids, or other OTC (over the counter) medicines.

<u>Medication/Vitamin/Supplements</u>	<u>Dosage</u>	<u>How Often Do You Take</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

See Attached List

Patient Signature: _____

Date: _____