**8PATIENT 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 they cause)*

| MEDICATION/FOOD/LATEX ALLERGY | REACTION |
|---|---|
| | |
| | |
| | |

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

| MEDICATION/VITAMIN/SUPPLEMENTS | DOSAGE | HOW OFTEN DO YOU TAKE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

❑ SEE ATTACHED LIST

| PREFERRED PHARMACY: | PHARMACY PHONE NUMBER & CITY: |
|---|---|
| | |

**PATIENT SIGNATURE:** _____ **DATE:** _____