

Patient Current Medication Form

*List all medications you are taking, include over-the-counter medications (e.g., Aspirin, antacids, vitamins and herbals).

I am not Allergic to any medications

Medication Allergy	Reaction (what happens when you take this medication)

I am not taking any medications at this time.

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Medication: _____ Strength: _____ How often: daily 2 times 3 times 4 times
 Reason for taking: _____ Date started: _____
 Doctor that prescribed this medication: _____

Patient Signature: _____ Date: ____/____/____