Medication List

Patient Name:		Date:
DOB:	SS#:	SC#:
Tobacco:	Alcohol:	Street Drugs:
Allergies/Adverse Reactions:		

Medications – Including Prescriptions, Over-the-Counter Medications, and Herbal Supplements

Drug Name/Strength/Dose/Route/Frequency	Start Date	Stop Date	Reconciliation Date	Initials

Provider Signature: _____ Date: _____

The list of medications and allergies provided is complete and accurate.

Patient Signature: _____ Date: _____