MEDICATION LIST

Date _____

PATIENT: _____ **DOB:**_____

ALLERGIES: q NKDA or List_____

List all prescribed and over the counter medications, supplements, herbs, salves and ointments.
Remember to update with start & stop date. If exact date is not known, enter approximate date or "UNKNOWN"
If no medications taken, please write "NONE" on top line under Medication Name. Doctor should document in his/her progress note that list was reviewed.

Medication Name	Dose	Frequency	Route / Method Taken (oral,inject,etc)	Date Started	Date Stopped