# MEDICATION RECORD

**Please complete the following for review by your provider.**

Name: ______________________ Birth Date: ____/____/____ Age: ________

Today's Date ____________________

Update - Patient Reviewed:
Initials: __________ Date: __________
Initials: __________ Date: __________
Initials: __________ Date: __________
Initials: __________ Date: __________

## Medications

**Allergies to Medications:** O None O Yes, list:

Latex Allergy/Sensitivity? O Yes O No

Metal Allergy? O Yes O No

| Medication | Allergic Reaction |
|---|---|
| | |
| | |
| | |

**Medications** you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

| Medication | Dosage | Medication | Dosage | Medication | Dosage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

☐ See separate medication list

List any food allergies and reaction:
☐ *None*

*For Office Use Only:*

**Medication Updates**

| Date | Medication | Dosage | Note |
|---|---|---|---|
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Physician Reviewed:
Initials: ______ Date: ______
Initials: ______ Date: ______
Initials: ______ Date: ______
Initials: ______ Date: ______