DATE: _____ MR#:_____

NAME: _____

NAME OF PHARMACY: _____

We are making every effort to keep your Medical Record up to date. In order to do this, it is important that we know what medications you are currently taking. You can help in this effort by completing this form, we apologize if you have completed this before, but it is important for us to keep this up to date. If you need help with this form, please ask a Medical Assistant when you come in for your visit or are called back to see the physician.

List any medications you are currently taking including: over the counter drugs and any medication that you take occasionally. You may complete this area or attach a list of your own.

NAME OF DRUG	DOSAGE	HOW OFTEN TAKEN	ORDERED BY WHOM?	REASON FOR TAKING?