



## Medication Chart for: \_\_\_\_\_

PATIENT NAME

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please list any **allergies to medications** \_\_\_\_\_

Please list any **food allergies** (peanuts, eggs, shellfish, etc.) \_\_\_\_\_

Please list all current prescriptions and over-the-counter medications that you are taking. Please update this list every time you come to the office.

### PRESCRIPTIONS

Name of Medication	Dose (total mg)	How many times daily?	When do you take it? (AM, PM? After meals?)	Who prescribed? (Dr's last name)	Why do you take this medication?	Side effects? (Describe them)
EXAMPLE: Macrobid	100mg	2	AM and PM	Dr. Gehring	Bladder Inf.	No

### OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBAL REMEDIES
