

****EXAMPLE ONLY** Patient Medication List **EXAMPLE ONLY****

Medications (please include Herbs and over-the-counter)		DATE: <i>Today's Date</i>		DATE: <i>Next Visit</i>		PRESCRIBER
		Dose	Frequency	Dose	Frequency	
1	<i>Medication 1</i>	<i>100mg</i>	<i>am & pm</i>	This area is left blank for future visits. Your medications will be updated, as needed, by office staff. In the future, please bring a list of any new medications or changes, or simply bring the pill bottles with you. Thank you.		<i>Dr. Duck</i>
2	<i>Medication 2</i>	<i>50mg</i>	<i>am</i>			<i>Dr. Duck</i>
3	<i>Medication 3</i>	<i>200mg</i>	<i>4 x/day</i>			<i>Dr. Duck</i>
4	<i>Medication 4</i>	<i>650mg</i>	<i>3 x/day</i>			<i>Dr. Goose</i>
5						
6						
7						
8						
9						
10						
Reviewed By:		Nurse Nancy	N.N.			

Patient Name:
 Allergies:
 Pharmacy:

Phone:
 DOB:

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