# Medication List

Name: DOB:

Date completed:

Local Pharmacy: Phone:

Mail Order Pharmacy: Phone:

Please list all prescription and non-prescription medications as well as vitamins and supplements that you are currently taking:

| Medication Name: | Dose / MG | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are you ALLERGIC to or have you had any unusual reactions to medication, radiology contrasts, or an allergy to shellfish? If so, please list the name of the drug and the reaction. If none, please write "NONE".