MEDICATION LIST

Please include all medications and supplements, including brand names of over-the-counter products, and the current dose. **This information is used to monitor for medication safety as well as to provide you/your child with the best clinical advice.**

Patient Name _____ Today's Date: _____

Date of Birth _____

Any known allergies: ☐ No ☐ Yes *(please list any allergies (seasonal, drug etc.) in the box provided)*

Allergy	Severity Level	Reaction type
	☐ low ☐ medium ☐ high	
	☐ low ☐ medium ☐ high	
	☐ low ☐ medium ☐ high	
	☐ low ☐ medium ☐ high	
	☐ low ☐ medium ☐ high	
	☐ low ☐ medium ☐ high	

CURRENT MEDICATIONS: (Prescriptions, Pain Meds, Over the Counter Meds, Vitamins, Herbals)

Drug	Dose/Amount	Frequency/Route	Brand Name	Reason for taking	Taking for how long