MEDICATION RECORD FORM

Your Name:_____

Your Primary Doctor:_____**Primary Doctor's Phone Number:**_____

Other Doctor:_____**Other Doctor's Phone Number:**_____

Your Pharmacy:_____**Pharmacy's Phone Number:**_____

Your Drug Allergies:_____

Please list all prescription medications and all over-the-counter medications, including vitamins or other nutritional supplements, pain relievers, antacids, laxatives and herbal remedies. Please bring this list on the day of your appointment.

Medication	Units/Mgs	Dose	Reason for Use