CURRENT MEDICATION LISTING

PLEASE INCLUDE PRESCRIPTIONS, OVER-THE-COUNTERS, HERBALS, VITAMIN/MINERAL/DIETARY SUPPLEMENTS IN THIS LISTING

PATIENT NAME__________________________________ DOB:_______________ DATE:______________

DATE OF LAST INFLUENZA VACCINE: MO/YR_________________ WHERE:__________________________

MEDICATION NAME	DOSAGE	FREQUENCY Once a day Twice a day, etc.	ORAL ROUTE	OTHER ROUTE TOPICAL, RECTAL, SUBLINGUAL

Office use only CHART #:

Dos:_________ Current Medications verified on _____________________ Patient's initials ___________
Dos:_________ Current Medications verified on _____________________ Patient's initials____________

Dos:_________ Current Medications verified on _____________________ Patient's initials____________