To help your record accurately we are asking you to complete this list of all your current medications. This list should include the medication name,strength, and dose. Please include any over the counter medications, vitamins, and herbal supplements.

Name:	**Address:**
Phone Number:	
Birth Date:	
Please identify your Primary Care Physician and	

Please provide us with the name and telephone number of your preferred pharmacy:		
Name:		
City:	**Telephone:**	

Allergic To /Describe Reaction:	**Allergic To /Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name

Arthritis Clinic and Medical associates PC

(2019