MEDICATION LIST

Dear Patient: Please keep an up to date list of your medications including over the counter and herbal remedies that you may be taking, and bring it with you to your physician or the hospital.

Name: (print) _____ Birth date: _____ Age: _____

Primary Care Physician: _____ Specialists: _____

ALLERGIES: _____

_____

MEDICATIONS:

Name of Medication	Dosage	Frequency	Comment

MEDICAL HISTORY:

Past: _____

Surgeries: _____

Current: _____

_____

IMMUNIZATION	YEAR RECEIVED
Dip-Tetanus	
Influenza	
Pneumonia	

Hospital Patient Label