MEDICATION LIST

Patient Name:

For office use only

Who is your preferred Pharmacy?

Location?

Who is your mail order Pharmacy?

List any medication allergies and the reaction:

Do you have an allergy or had a reaction to any of the following:

□ Latex □ Eggs □ Iodine □ Shellfish/Seafood □ Soy □ Dye used in a CAT scan or other imaging studies

Have you been prescribed narcotic pain medications in the past 1-year (if not listed above)? □ Yes □ No

List the medications you are currently taking. (Please include any vitamins, over the counter, and supplemental)
a separate sheet can be provided for additional medications

Medication	Dosage	Frequency