MEDICE PRIMARY CARE

MEDICATION FORM

List all patient medications prior to assessment. Include over-the-counter, alternative medications, herbals and prescriptions

☐ **Check here if patient is NOT currently on any medication.**

Patient Name (Last, First) : _____

Date of Birth: _____ ALLERGIES:_____

Medication	Dose	Route	Frequency	Documented By: Initials/Date	Provider Decistion to DISCONTINU USE Date/Time/Initials

Pharmacy Name: _____ Phone Number: _____

Completed By: _____ _____ _____ _____

Nurse/MA Signature Credentials Date Time

Reviewed By: _____ _____ _____ _____

Provider Signature Credentials Date Time