Best Possible Medication History

(Include all current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS

Name: ----------

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
dd/mm/yyyy	Brand and Generic name (If available)		Quantity?	Route?	Frequency?	Food?			

Whenever you see a doctor, including your primary care physician and any specialists, review and update this medication list.
After any hospitalization, check with your doctor or pharmacist to review this medication list.

ALLERGIES

Agent	Reaction

Pharmacy: ----------

Pharmacist: ----------

Telephone #: ----------

Date last reviewed: ----------

March 2007