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MEDICATION RECORD

Patient Name: _____ Home Phone: _____

Birthdate: _____ Age: _____

Pharmacy Name: _____ Phone Number: _____

Current Medication: _____ (cell): _____

Medication Allergies: _____ ☐ None

Medical Problems: _____ ☐ None

Patient agrees to take medication: _____ YES _____ NO

Risk(s) and benefit(s) of medication were discussed: _____ YES _____ NO

Date	Medication	Dosage	Disp #	Instructions	MD

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