Medication History

Please include all prescription and non-prescription medications **including** vitamins, supplements, herbals, and over-the-counter drugs. Include medications that you only take as needed or not on a regular basis.

If none, write "none."

If no longer taking, cross out with a line.

Patient Name: _____

Date of Birth: _____

Account Number: _____

Original Date Completed: _____

Updated (initial and date): _____ / _____

_____ / _____ / _____ / _____

Name of medication	**Dose**	**How often**	**Route** (mouth, eyes, inhaler, IV, injection, skin, etc.)