Patient Medication Log

Please provide a complete list of your current medications and their doses. This includes over-the-counter (OTC) medications, herbal supplements and vitamins.

Name: _____ **DOB:** _____ **Allergies:** _____
Pharmacy: _____ **Pharmacy number:** _____

Date	**Medication Name**	**Dosage** (Example: 50mg)	**Frequency** (Example: once daily)	**Route** (Example: By mouth)	**Patient Initials**	**Staff Date and Initial**

Date Patient Signature Patient's Initials