Patient Medication Form

Date: _____

Name _____ Birthdate: _____

Are you ALLERGIC to any medications?

☐ **No**, I have no known allergies to medication.

☐ **Yes**, I have an allergy to the medication(s) listed below:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Do you take any **BLOOD THINNERS? (circle one) Yes No If yes list below**

Do you have a **PACEMAKER?** ☐ Yes ☐ No

Do you have a **DEFIBRILLATOR?** ☐ Yes ☐ No

Please list all medications that you are currently taking.

Medication Name (prescription and over the counter)	Dosage (mg/g/ml/iu)	Form(tablet/liquid/spray)	How often (daily/PRN)	How many