Bring this form with you and show it to your medical professionals any time you have a doctor's appointment, you have to go to the hospital, and whenever you have a new prescription filled at your pharmancy.

Patient Name: _____ **Date of Birth**: ____/____/_____ **Date Form Updated:** ____/____/____

Allergies/Reaction: _____

_____

Medications: (all known prescriptions, over-the-counter, herbals and supplements)

	Name (Generic or Brand)	**Dosage**	**Frequency** (How often)	**Route** (oral, topical, injection)	**Reason**
	Metoprolol (example)	*5 mg tablet*	*2x/day*	*Oral*	*Blood pressure*
	Latanoprost (example)	*1 drop both eyes*	*1x at bedtime*	*Topical*	*Glaucoma*
	Ibuprofen (example)	*200mg tablet*	*As needed*	*Oral*	*Headache/ Arthritis pain*
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