Physician: _____

Patient Medication List

Date: 04/14/11

Patient Name: _____ Date of Birth: _____ Nextgen Acct # _____

Please list all prescription, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers, and homeopathic remedies.

** Pharmacy and Pharmacy Number is required for First State Orthopaedics to prescribe medications**

PHARMACY: _____ PHARMACY NUMBER: _____

PHARMACY: _____ PHARMACY NUMBER: _____

MEDICATION NAME	DOSE (mg, units, drops)	WHEN TAKEN (daily, at bedtime, etc)	REASON (blood pressure, diabetes, etc.)

LATEX ALLERGY (required) Please circle one: YES or NO

ALLERGIES to Medications:_____ REACTION:_____

_____ _____

_____ _____

Processed by:_____ Date: _____ Processed by: _____ Date: _____

Processed by:_____ Date: _____ Processed by: _____ Date: _____

Processed by:_____ Date: _____ Processed by: _____ Date: _____

First State Orthopaedics