NEW PATIENT MEDICATION LIST

Name:	DOB:

Source of medication list:	Drug Allergies/Describe Reaction:
☐ Patient wallet card ☐ Patient/ family recall ☐ Pharmacy_____ ☐ Primary care physician list ☐ Other_____	_____ _____ _____ _____ _____ _____

Have you had a flu shot?	☐ YES If yes, when_____ ☐ NO
Have you had a pneumonia vaccine?	☐ YES If yes, when_____ ☐ NO

CURRENT MEDICATION LIST

List below your current medications including over the counter and herbal medications.

NAME OF MEDICATION	DOSE	FREQUENCY	ROUTE

Medication Disclaimer: This list represents the medicines you are taking based on the information you have given us. If you have any questions or concerns about medicines we did not prescribe in this practice please contact that prescribing physician.

Reviewed:
By: _____ Date:_____

_____
PATIENT SIGNATURE DATE

Physician / Allied Health Professional