UNIVERSAL MEDICATION FORM

Today's Date: _____

Patient's Name:	
Patient's Date of Birth:	
Phone #:	
Allergic To: Reaction:	Allergic To: Reaction:
Allergic To: Reaction:	Allergic To: Reaction:
Allergic To: Reaction:	Allergic To: Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

Date Prescribed	**Name of Medication/Dosage**	**Directions / How often taken**	**Prescribing Doctor's Name Reason for RX**	**Date RX Stopped** ***If Applicable***