Annual Patient Medication/Drug List

Patient's Name:_________________________________ Date Of Birth: ____________

ALL PATIENTS: This information will be held **strict confidence** and will be used only for safe and appropriate care. Please provide the medication/drug name, the dosage you take, and the frequency of which you take the medication drug.

Medication used during treatment may interact with both prescription and non-prescription drugs; including herbal supplements. These reactions may result in **SEVERE INTERACTIONS.** It is **extremely** important that you inform your provider of **any** drug you currently use or may have taken so that this may be considered in planning your treatment.

Foster's Pharmacy, Conway's Pharmacy and **Wal-Mart of Mt. Vernon** are preferred by the Health Center. Most prescriptions are electronically transmitted for your convenience. Please list **Foster's Pharmacy, Conway's, Wal-Mart** or another pharmacy you prefer.

Pharmacy Name:_________________________ **Pharmacy Town:**______________________________

Medication:	Dose	How often	Why do you take it?

Print Name of Patient or Responsible Party:___________________________________ Date:_________________

Signature of Patient or Responsible Party:____________________________________ Date: ________________

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