

PATIENT NAME

PRIMARY CARE PHYSICIAN/PHONE

PHARMACY/PHONE

Be sure to list all medications you are taking, including natural remedies and over-the-counter medications such as aspirin and vitamins

ask your doctor or pharmacist to check for

	MEDICATION	PURPOSE	DOSAGE/FREQUENCY	DURATION START - STOP	SOURCE	SIDE EFFECTS COMMENTS/QUESTIONS	Potential Adverse Drug Events	Generic/Other Less Costly Alternative
sample	<i>Accupril</i>	<i>high blood pressure</i>	<i>10mg/once daily</i>	<i>6/02-</i>	<i>Dr. Smith</i>	<i>OK to take with aspirin?</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	<i>Kava Kava</i>	<i>stress/anxiety</i>	<i>350mg/ once daily</i>	<i>1/03-</i>	<i>Health Store</i>	<i>OK to take with Accupril?</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
1.							<input type="checkbox"/>	<input type="checkbox"/>
2.							<input type="checkbox"/>	<input type="checkbox"/>
3.							<input type="checkbox"/>	<input type="checkbox"/>
4.							<input type="checkbox"/>	<input type="checkbox"/>
5.							<input type="checkbox"/>	<input type="checkbox"/>
6.							<input type="checkbox"/>	<input type="checkbox"/>
7.							<input type="checkbox"/>	<input type="checkbox"/>
8.							<input type="checkbox"/>	<input type="checkbox"/>
9.							<input type="checkbox"/>	<input type="checkbox"/>
10.							<input type="checkbox"/>	<input type="checkbox"/>
11.							<input type="checkbox"/>	<input type="checkbox"/>
12.							<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIC REACTIONS
