Medication List

PATIENT NAME DATE

DATE OF BIRTH AGE

Please complete your list of current medications.
List all medicines currently used including prescription medicines, complementary, alternative and over-the-counter medicines. Remember medicines come in different forms including tablets, liquids, inhalers, drops, patches, creams, suppositories and injections.

If you are unable to complete your medication list, ask your local Pharmacist or General Practitioner to assist.

NAME OF MEDICINE BRAND OR GENERIC NAME	STRENGTH	HOW MUCH I USE & WHEN	SPECIAL INSTRUCTIONS OR RECENT CHANGES	WHAT IS THE MEDICINE FOR
eg. Aspirin	100mg	1 tablet daily	Take regularly	To thin blood

ALLERGIES OR PREVIOUS PROBLEMS WITH MEDICINES

Are you allergic to any medicines, sticking plaster, latex, rubber, iodine, x-ray dyes, seafood, eggs, peanuts or fruit? ☐ NO ☐ YES

LIST

TYPE OF REACTION