CARLS CENTER FOR CLINICAL CARE AND EDUCATION

CENTRAL MICHIGAN UNIVERSITY

Medication List

Patient Name: _____ Date of Birth:_____

Today's date: _____

Which of the following types of medications have you EVER taken?

☐ Diuretics ☐ Anti-inflammatory ☐ IV Antibiotics ☐ Chemotherapy

(Please include **CURRENT** prescription drugs, over the counter drugs, vitamins, supplements & herbals)

Name of Medications	**Amount**	**Frequency** *QD -Once/day, BID-2x/day, TID-3x/da, QID4x/day,Other____*	**Route** *(Mouth, IM, SubQ, Rectal, Patch, Ear, Eye, Skin, Other)*	**Special Instructions or Reason for Taking Medication**

Allergies & Description of Reactions:_____

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