DIGESTIVE DISEASE & NUTRITION CENTER OF WESTCHESTER

PATIENT NAME:

DOB:

DATE:

MEDICATION LIST

PLEASE LIST BELOW ALL THE MEDICATION AND SUPPLEMENTS YOU ARE TAKING.

A COPY SHOULD BE RETAINED BY THE PATIENT FOR FUTURE VISITS AND PRESENTED TO ALL DOCTORS' OFFICES THEY VISIT. ANY NEW MEDICATIONS PRESCRIBED SHOULD BE ADDED TO THE LIST AND ANY MEDICATIONS THAT HAVE BEEN DISCONTINUED SHOULD BE CROSSED OUT AND CIRCLE DC

DATE RECORDED: _____ MEDICATION HISTORY PROVIDED BY: _____

VERIFIED BY (MEDICAL ASSISTANT): _____

ALLERGIES IF ANY: _____

_____

MEDICATION NAME (WRITE LEGIBLY)	DOSE (mg, mcg,)	ROUTE (PO, GT, SC, IV)	FREQUENCY	**Medication Status (Circle as appropriate)**	
				C: Continued	**DC: Discontinued**
1.				C	DC
2.				C	DC
3.				C	DC
4.				C	DC
5.				C	DC
6.				C	DC
7.				C	DC
8.				C	DC
9.				C	DC
10.				C	DC
11.				C	DC
12.				C	DC
13.				C	DC
14.				C	DC
15.				C	DC