Patient's Name: ________________________________ DOB: ___________

My Medications:

Please list below all the medications you are currently taking along with what time of day you usually take that medication. If you would prefer our staff assist you with this, please bring in your medications and we would be happy to help you fill this out. We will send this to your primary care provider to compare to their medication list.

Prescription medication name and strength	When during the day do you take this medication? How many do you take at that time?				
	Morning	Noon	Evening	Bedtime	Only if I need it/as needed
Example: Crestor 5mg				***1***	

Non-prescription (OTC) medication name and strength	When during the day do you take this medication? How many do you take at that time?				
	Morning	Noon	Evening	Bedtime	Only if I need it/as needed
Example: Tylenol 325mg	***2***	***1***	***1***		

Provider's Signature: ____ Date: ______________

With locations in Frenchtown, Libby, and Missoula