CURRENT LIST OF MEDICATIONS as of _____

Name of Individual: _____ DOB: _____

Primary Care Physician _____ Phone Number: _____

Address: _____

NAME (GENERIC/COMMON)	START DATE	RX / OTC	DOSAGE / FREQUENCY	PURPOSE	PRESCRIBED / APPROVED BY	SIDE EFFECTS

This form may be emailed to FamilyTouchReporting@gmail.com

BRING A CURRENT LIST OF MEDICATIONS TO ALL MEDICAL AND DENTAL APPOINTMENTS