Patient Name

_____

Date of Birth: _____

Date of Visit: _____

Prescribed Medicines From Your Doctor

Medicine Name	Dose	Frequency	Why Taking?	Expired?	Need Refill?	Taking as Prescribed?
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N
				Y/N	Y/N	Y/N

Over-the-Counter Medicines, Such as Vitamins, Herbal Medicines, and Cold Medicine

Medicine Name	Dose	Frequency	Why Taking?