Medication Record

Patient: _____ **DOB:** _____ **UTPA MD:** _____

★**Medication Allergies:** _____

★**Other Allergies: (foods, latex, betadine etc.)** _____ **Posted on Chart:** _____

★**Significant Health Conditions:** _____

Primary Care Physician: _____ **Phone Number:** _____

_____ **Care Physician:** _____ **Phone Number:** _____

_____ **Care Physician:** _____ **Phone Number:** _____

Pharmacy: _____ **Phone Number:** _____

MEDICATIONS: LIST ALL CURRENT MEDS & SUPPLEMENTS.

Rx Start Date	MEDICATION OR DRUG SUPPLEMENTS	Dos-age	How often	✓if OTC	✓ if Prescription	If Prescription please list name of Prescribing Physician	RX Stop Date UTPA only