NORTH HILLS FAMILY MEDICINE

Name: _____

Date Update: _____

Current Medications List

Medications (Prescription & Over the Counter)				
Medication Name	**Dose**	**Frequency**	**Prescribing Doctor**	**Notes**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				

Allergies	
Medication/Other	**Type of Reaction**
1.	
2.	
3.	
4.	
5.	

Specialists Seen	
Name	**Phone Number**
1.	
2.	
3.	
4.	
5.	