MEDICATION LIST

UROLOGY GROUP,PA

PATIENT NAME ______________________________ DATE__________________________

PLEASE LIST ALL PRESCRIPTION MEDICATIONS (AS WELL AS OVER THE COUNTER MEDICATIONS, HERBAL SUPPLEMENTS AND VITAMINS)

	MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

PLEASE LIST ALL MEDICATION ALLERGIES

1 ____

2 ____

3 ____

4 ____

SIGNATURE ____________________________________ DATE OF BIRTH:____________________________