LIST OF MEDICATIONS

All prescriptions, over-the-counter, herbals, and
Vitamins/minerals/dietary (nutritional) supplements

If you don't take any medications please indicate "NONE"

_____

_____ _____ _____ _____

(Legal) First Name (Legal) MI (Legal) Last Name DOB

Medication Name:	Dosage:	Frequency:	Route:	Prescribing Physician:

Due to Medicare's Physician Quality Reporting System (PQRS) required measures it is crucial you help us obtain all the necessary information to the best of your knowledge.

Patient Signature: _____ Date: _____

Revised 09/30/16