CHI St. Luke's Health

Medication List

Patient Name: _____ DOB: _____ Todays Date: _____

Pharmacy Name/Number: _____

Please list all current medications; include strength, dosage and any instructions. Please also include any over the counter vitamins or supplements.

Medication	Dosage	Frequency	Prescriber

Medication & Food Allergies (please list any med/food allergies you may have)	Reaction