HEMATOLOGY ONCOLOGY Consultants, Ltd

PATIENT MEDICATION LIST

Name: DOB: Allergies:

Pharmacy (with address): Pharmacy phone:

Names of doctors you see:	Medical Reason (i.e.,general health care, asthma, heart problem):
1	
2	
3	
4	
5	

List all medications you currently use/take: Include all prescriptions, over-the-counter meds, herbals and supplements

	Start date	Medication	Dose	Directions (how often):	Taking it for:	Dr. who prescribes it?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						

Complete this form and keep it updated; bring it with you to each appointment.