Madison Ridgeland Medical Clinic

Medication List

Patient Name: _____ Date: _____

Pharmacy _____ Location _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATION**

Allergies or intolerance to medications (include type of reaction):

_____

_____□ NONE

Name of Medication	Prescribed By	Dosage	How Often	Refills Needed