ORTHOPAEDIC SPECIALISTS OF CENTRAL ARIZONA – MEDICATION LIST

PATIENT NAME**:** _____ DATE OF BIRTH**:** _____

ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects	ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects

Please list all medications you currently take, including Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements and Eye drops.

DRUG NAME	DOSE	ROUTE e.g. oral, injectable, inhaled	FREQUENCY	REASON

Patient Signature: _____ Date: _____

Reviewing Staff: _____

Reviewing Staff Signature: _____ Date: _____

Revised 4/17/2018