ADVANCED OBSTETRICS AND GYNECOLOGY, LLC

"Comprehensive Healthcare for Women"

MY MEDICATION LIST **Today's Date: ___ / ___ / _____**

Patient Name: ______________________________________ **DOB: ___ / ___ / _____**

Please bring this form with you on the day of your appointment. A complete record of your current medications is important to provide safe and effective care.

Do you have any allergies to any medication? ☐ NO ☐ YES

If yes, please list allergies: ____

____

List ALL of the medications that you are currently taking.
Include: eye drops, inhalers, contraceptives, patches that contain medication, over-the-counter medication, vitamins, dietary and herbal supplements.

Name of medication	Dose or strength	How many times a day do you take this medication?	Who prescribed this for you?	What do you take this for?