SUMMA HEALTH CARE

Medication Record

Name: _____

DOB: _____

Date: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____ Fax Number (If known): _____

Pharmacy Address or Cross Streets: _____

Do you have a latex allergy? ☐ Yes ☐ No

Do you have any allergies or sensitives to certain medication or food? ☐ Yes ☐ No

If so, what are you allergic to? _____

***Please list <u>all</u> medication/supplements/vitamins you are currently taking daily or as needed below*:**

Date:	Medication Name:	Dosage Given:	Frequency: (i.e. 2x per day)	Time:	AM / PM

Patient Signature: _____