## Midwest Pain Management

## PATIENT MEDICATION LIST Prescribed, Over the Counter, Herbal, etc.

| Name:   |  |             |          | Date              | Date of Birth: |              |                   |  |
|---|--|-------------|----------|-------------------|----------------|--------------|-------------------|--|
| Pharmacy Name:                                      |  |             | _ Phar   | Pharmacy Phone #: |                |              |                   |  |
|   | Allergies o                                      | r Intoleran |          |                   | ns, latex, s   | skin disinfe | ectants, and what |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
| Date List Medication(s) name decade how it is taken |  |             |          |                   |                |              |                   |  |
| Date  | List Medication(s) name, dosage, how it is taken |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
|   |  | <u> </u>    | <u> </u> |                   |                |              |                   |  |
| Reviewed  |  |             |          |                   |                |              |                   |  |
| (Patient &  |  |             |          |                   |                |              |                   |  |
| RN initialed  |  |             |          |                   |                |              |                   |  |
|   |  |             |          |                   |                |              |                   |  |
| Reviewed  |  |             |          |                   |                |              |                   |  |
| (Patient &  |  |             |          |                   |                |              |                   |  |
| RN initialed  |  |             |          |                   |                |              |                   |  |