TUSTIN IRVINE INTERNAL MEDICINE GROUP, INC.

# MEDICATION LIST

| PATIENT INFORMATION | |
|---|---|
| **Name:** | **Date of Birth:** |

Please list all medications you are currently taking: prescriptions, over the counter medications, dietary supplements, herbals and medications taken on an as needed basis.

| MEDICATION | STRENGTH | TAKEN HOW OFTEN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any allergies to medications:

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |

**DATE MEDICATION LIST COMPLETED: _____ Page: _____ of _____**

Form created 4/30/2012