

List ALL prescription AND non-prescription (over the counter) medications currently used. Include any occasionally used medication (prescription and non-prescription) such as inhalers of EpiPens.

Participants Name: \_\_\_\_\_ Unit # \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Reason for taking this medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Approximate Date Started: \_\_\_\_\_  
 Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
 Side Effects: \_\_\_\_\_  
 \_\_\_\_\_  
 Storage Instructions (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Prescribing Physician: \_\_\_\_\_  
 Physician's Phone # : \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Reason for taking this medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Approximate Date Started: \_\_\_\_\_  
 Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
 Side Effects: \_\_\_\_\_  
 \_\_\_\_\_  
 Storage Instructions (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Prescribing Physician: \_\_\_\_\_  
 Physician's Phone # : \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Reason for taking this medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Approximate Date Started: \_\_\_\_\_  
 Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
 Side Effects: \_\_\_\_\_  
 \_\_\_\_\_  
 Storage Instructions (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Prescribing Physician: \_\_\_\_\_  
 Physician's Phone # : \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Reason for taking this medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Approximate Date Started: \_\_\_\_\_  
 Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
 Side Effects: \_\_\_\_\_  
 \_\_\_\_\_  
 Storage Instructions (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Prescribing Physician: \_\_\_\_\_  
 Physician's Phone # : \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Reason for taking this medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Approximate Date Started: \_\_\_\_\_  
 Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
 Side Effects: \_\_\_\_\_  
 \_\_\_\_\_  
 Storage Instructions (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Prescribing Physician: \_\_\_\_\_  
 Physician's Phone # : \_\_\_\_\_

Medication: \_\_\_\_\_  
 Strength: \_\_\_\_\_  
 Frequency: \_\_\_\_\_  
 Reason for taking this medication: \_\_\_\_\_  
 \_\_\_\_\_  
 Approximate Date Started: \_\_\_\_\_  
 Temporary: \_\_\_\_\_ Permanent \_\_\_\_\_  
 Side Effects: \_\_\_\_\_  
 \_\_\_\_\_  
 Storage Instructions (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 Name of Prescribing Physician: \_\_\_\_\_  
 Physician's Phone # : \_\_\_\_\_