ORTHOPAEDICS NEW ENGLAND

PATIENT MEDICATION RECORD

Date: _____

Patient Name: _____ Birth Date:_____

Do you have any medication allergies? □Yes □ No If so what are they?

_____

_____

DRUG NAME & STRENGTH	PILLS/DOSE	TIME/DAY	REASON FOR TAKING	STARTED	STOPPED
EXAMPLE: Medication Name	1 Pill	7:30am Daily	Cholesterol	9/24/04	---------

□ **CHECK HERE IF NOT TAKING ANY MEDICATIONS**

□ **CHECK HERE** if you consent to allow us to obtain an electronic listing of your medication record from your pharmacy. **We will compare the above listing to that of the pharmacy's.**

Preferred Pharmacy: Name_____

Address_____

Phone_____

HAVE YOU CHANGED PHARMACIES □ Yes □ No If so, complete the above.