Affiliates in OB/GYN, P.A.

MY MEDICATION LIST:

Patient Name:_____Date of Birth:_____

Do you have any allergies to any medications? YES NO

Medication	Reaction

List ALL medications you are currently taking including over-the-counter medication, vitamins, dietary and herbal supplements.

Name of medication	Dose/Strength	How many time a day do you take this?	Prescribed By	Why do you take this medication?