Northwest Suburban UROLOGISTS

MEDICATION LIST

PATIENT NAME: _____DATE OF BIRTH: _____ACCT#_____

ALLERGIC TO:	DESCRIBE REACTION:

In order to facilitate the process of filling your medications or obtaining medication information please provide us with your Pharmacy information below: (If you do not know exact address, please provide cross streets & town)

Pharmacy Name: _____ Phone# _____Fax#_____

Address: _____City_____Zip____ _____

PLEASE LIST ALL MEDICINES YOU ARE CURRENTLY TAKING. PLEASE INCLUDE PRESCRIPTION, OVER-THE-COUNTER MEDICATIONS VITAMINS AND HERBALS

DATE	MEDICATION NAME/DOSAGE	DIRECTIONS(WHEN TAKEN, HOW OFTEN)	DATE STOPPED