

ORTHOPAEDIC SPECIALISTS OF CENTRAL ARIZONA – MEDICATION LIST

PATIENT NAME: _____

DATE OF BIRTH: _____

ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects	ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects

Please list all medications you currently take, including Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements and Eye drops.

DRUG NAME	DOSE	ROUTE <small>e.g. oral, injectable, inhaled</small>	FREQUENCY	REASON

Patient Signature: _____

Date: _____

Reviewing Staff: _____

Reviewing Staff Signature: _____

Date: _____