ALASKA UROLOGY

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Patient Medication List

Patient Name: _____ Date: _____/_____/_____

Local Preferred Pharmacy: _____

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Time of Day (morning, noon, night)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Allergies

(Please list all known allergies, reactions and cause)

_____ No Known Drug Allergies (X or initials)

1.
2.

3.
4.
5.