Gateway Medical

Patient List of Medications

Date Recorded | Patient Name (Print) | Patient Date of Birth

Please list (or provide a copy) of all prescriptions, medications and over-the-counter drugs you currently take on a daily basis. Please also note the time taken, dosage, frequency and the reason for taking them:

TIME	NAME OF MEDICATION	DOSAGE	FREQUENCY	REASON FOR TAKING
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				

Please list (or provide a copy) of any drug allergies and reactions/side effects below:

Please list (or provide a copy) of all of vitamins and/or dietary supplements you take on a daily basis:

TIME	VITAMIN/SUPPLEMENT	DOSAGE	FREQUENCY	REASON FOR TAKING
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				
: AM/PM				

Preferred Pharmacy

Name of Pharmacy | Phone | Fax

Street Address | City / State | Zip

PO Box 2169 • Lexington, SC 29071-2169 • Phone (803) 358-8496 • Fax (833) 972-5582