UNIVERSITY ORTHOPAEDIC CLINIC

ORTHOPAEDIC · SPINE · SPORTS MEDICINE

PATIENT NAME _____ **DATE** _____

MED REC # _____

CURRENT MEDICATIONS:

☐ **I have brought in a list of medications which may be scanned into my file rather than completing the list below.**

Please list all current Prescription Medications:

	MEDICATION	DOSAGE	TAKEN HOW OFTEN		MEDICATION	DOSAGE	TAKEN HOW OFTEN
1				16			
2				17			
3				18			
4				19			
5				20			
6				21			
7				22			
8				23			
9				24			
10				25			
11				26			
12				27			
13				28			
14				29			
15				30			

Please list all Over the Counter Medications, Herbals, Vitamin/Mineral Dietary (Nutritional Supplements):

	MEDICATION	DOSAGE	TAKEN HOW OFTEN		MEDICATION	DOSAGE	TAKEN HOW OFTEN
1				16			
2				17			
3				18			
4				19			
5				20			
6				21			
7				22			
8				23			
9				24			
10				25			
11				26			
12				27			
13				28			
14				29			
15				30			

PATIENT SIGNATURE _____