Midtown Neurology Patient Medication List

Patient Name : _____

Drug Allergies: _____

Name of Your Pharmacy: _____

Pharmacy Address : _____

Pharmacy Phone # : _____

Pharmacy Fax # : _____

Current Medication(s)	Dosage per pill	#of pills taken per day	#of times taken per day	Reason for Taking	Effectiveness (Rate 0-100%)	Side Effects

Past Medication(s)	Dosage per pill	#of pills taken per day	#of times taken per day	Reason for Taking	Effectiveness (Rate 0-100%)	Side Effects