



NEW PATIENT MEDICATION LIST

PATIENT IDENTIFICATION

1. Today's date: _____

 Child's Name (please print)

 Child's Birth Date

 Your Name (please print)

 How are You Related to the Child?

2. Is the child allergic to any medicine, vitamin, or herbal or has he/she had a bad reaction to any medicine, vitamin or herbal in the past? *(circle yes or no)*

Yes No

2a. If "yes," please list the name(s) of the medicine, vitamin or herbal and describe what happened:

Name of medication, vitamin or herbal

What happened to the child?
 (describe the allergic reaction)

3. Is the child currently receiving breast milk? *(circle yes or no)* Yes No
(Some medications taken by a mother can be passed on to the child through breast milk)

3a. If "yes," please list the names of all medicines, vitamins and herbals the mother is taking:

4. Which pharmacy fills your child's prescriptions? _____
Pharmacy Name Pharmacy Phone Number

5. Please list the names and doses of all medicines, vitamins, herbals and over-the-counter medicines the child is currently taking:

Name of medication, vitamin or herbal
 or over-the-counter medicine

How much does the
 child take? (dosage)

How often?
 (frequency)

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 Practitioner Signature

 Date

Child's Name (please print) _____

Name of medicine, vitamin or herbal or over-the-counter medicine	How much does your child take? (dosage)	How often? (frequency)

Practitioner Signature _____

Date _____