Full Name: _____
Date of Birth: _____

PERSONAL MEDICATION REGISTRY

Premier HealthCare Associates

PLEASE LIST ANY ALLERGIES: _____

Please list all prescription and over the counter medications that you CURRENTLY taking.

PLEASE PRINT

MEDICATION NAME	DOSE (mg, units, mcg, etc.)	INSTRUCTIONS	FOR TREATMENT OF	PRESCRIBING Dr.
Example: DIOVAN	160mg	1 tablet by mouth once a day	high blood pressure	Dr. John Doe
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

APPOINTMENT DATE _____

PHYSICIAN NAME _____