

Medication List

Please complete each column on this medication list with the requested information and bring it with you to <u>every</u> appointment.

Please include <u>all</u> over-the-counter medications, supplements and vitamins that you are taking as well.

Please place a check mark by the name of each medication that you need a refill for. Your pharmacy may also fax requests for your refills.

(Only medications prescribed by our physicians will be refilled).

| Patient Name: | | Date of Birth: | | Today's Date: _ | | |
|---------------|--------------------|---------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------|
| ✓ | Name of Medication | Number of Refills left on bottle of Medication | Dosage of Medication | List the number of tablets and how often you are <u>presently</u> taking the <u>Medication</u> | Reason for taking the Medication | Name of physician prescribing the Medication |
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| Number of Refills left on bottle of Medication | Dosage of Medication | List the number of tablets and how often you are <u>presently</u> taking the Medication | Reason for taking the Medication | Name of physician prescribing the Medication |
|---------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
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| | bottle of | Refills left on bottle of Medication | Refills left on bottle of Medication and how often you are presently taking the | Refills left on bottle of Medication and how often you are taking the medication |

Please let us know if you need refills on any of your diabetic supplies.

| Name of Glucose Meter | Brand of Test Strips Needed | Size of Lancets Needed | Glucose Control Solution for your meter (yes or no) | Insulin Syringe (Needle length and gauge) | Insulin Pen Needles (Needle length and gauge) |
|--------------------------|-----------------------------------|------------------------|-----------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|
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PLEASE NOTE: IT IS IMPORTANT TO HAVE THE CORRECT DATE AND TIME SET ON YOUR METER.

Please see a member of our staff if you need assistance with these settings. Bring your glucose meter to every appointment. Or if you have a computer, please see us to obtain a free cable which will allow you to download your meter at home in preparation for your appointment. Good record keeping is essential to good health care.