

Patient Medication Intake Form

Patient Name: _____

Date: _____

Weight (lb) _____ **Height (in)** _____ **(Needed for Medicare Reporting)**

*****Please list ALL known prescriptions, over-the counters, herbals & vitamin/mineral/dietary (nutritional) supplements. All list medications must have name, dosage, frequency and route of administration.**

Medication Name	Dosage	Frequency	Route of Administration
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			