IBH

PLEASE PRINT

Patient Name: _____ DOB: _____

Pharmacy Name: _____ Address:_____

Pharmacy Phone:_____ Pharmacy Fax Number: _____

List ALL current medication below including any vitamins, supplements, herbs, and birth control

Medication Name Include (extended release if used)	**Dosage** (mg of each pill)	**Directions** (# of pills and times of day or frequency)	**Medical Condition** (Why med is taken)