HOME MEDICATION LIST

FILL OUT FORM AS COMPLETELY AS POSSIBLE

Winter Haven Hospital
Compassion. Innovation. Trust.

Today's Date_____

Patient Name_____

Date of Birth_____

Primary Doctor _____
Name/Phone Number

Information Provided By _____
Name/Relation to Patient

I have my medications filled at the following pharmacies:

Name	City/State	Phone #
Example: Walgreens	*Winter Haven/FL*	*(111) 111-1111*

ALLERGIES

Medication Name	Reaction
Example: Metoprolol	*Rash, Anaphylaxis*

LIST ALL MEDICATIONS including prescriptions, over the counter, vitamins, supplements and herbals

Medication Name	Dosage	Frequency	Reason for Taking	Last Dose Taken
Example: Metoprolol	*500mg*	*Twice a day*	*High Blood Pressure*	*This Morning*