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Patient Medication Form (PQRS)

Patient Name: _____ **Patient Date of Birth:** _____

Please list current medications below. Include **prescription, over-the-counter, herbals, or vitamins/ minerals/nutritional supplements**. If further space is needed, please use the back.

FORM MUST BE COMPLETED IN ITS ENTIRETY AS PER INSURANCE REQUIREMENTS

Medication Name	Dosage & Frequency	Delivery Method (Oral, Patch, Topical, Nasal, Inhaler, Drops, Suppository	Indication (Reason Used)	For updates only: Added And/ Or Removed & Date

PATIENT SIGNATURE: _____ **REVIEWED BY:** _____

Date: _____ **Date :** _____

UPDATES: Initial and Date: _____
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