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

**Date:** _____ **Date :** _____

**UPDATES: Initial and Date:** _____
**UPDATES: Initial and Date:** _____
**UPDATES: Initial and Date:** _____

**UPDATES: Initial and Date:** _____
**UPDATES: Initial and Date:** _____
**UPDATES: Initial and Date:** _____

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