Blossomwood Medical
primary care for adults

Medication List

Name: _____ DOB: _____

Male / Female / Transgender (circle one) Phone Number: _____

Pharmacy Name		Pharmacy Address

Allergies	Reaction (please describe: rash, itching, swelling)

Medication	Dosage	How often? How?	Reason for Taking	Date Started/Date Ended	Prescriber