HAMILTON
PHYSICAL THERAPY

LIST OF MEDICATIONS AND DRUG ALLERGIES

Patient Name: _____ Date: _____/_____/_____

Please list **ALL** medications that you are taking, including current prescription medications, over-the-counter drugs, vitamins and herbal supplements.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

❑ I'm currently not taking any medications.

Do you have any drug allergies? If **YES** please list the names of the drugs.

❑ YES - _____

❑ NO - I don't have any drug allergies.

Patient Signature: _____ Date: _____/_____/_____

Therapist Signature: _____ Date: _____/_____/_____