Brett Clarke, M.D., M.S.

PINON HILLS
Ear, Nose, Throat & Allergy

Stephen Smith, PA-C

HOME MEDICATION FORM

Name:	Address:
Phone Number:	
DOB:	Social Security #:
Primary Care Physician:	Pharmacy:
Emergency Contact / Phone Numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)	
Tetanus	Flu Vaccine(s)
Pneumococcal	
Pertinent Medical History	

Allergic To / Describe Reaction:	**Allergic To / Describe Reaction:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:

Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

PRESCRIP-TION DATE	NAME OF MEDICATION	DOSE / FREQUENCY	DATE STOPPED	NOTES: REASON FOR TAKING / DOCTORS INSTRUCTIONS

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