ARKANSAS QUICK CARE
URGENT CARE AND WALK-IN CLINIC

UNIVERSAL MEDICATION FORM

To treat you appropriately, we need to know all medications that you take and the dosages. As the patient, it is your responsibility to know your medications and dosages. If you are unsure, please call your pharmacy.

Keep this form in your wallet. Take this form to ALL doctor visits, when you go for tests and ALL hospital visits. Update the form as medications are added or stopped.

Name: _____ DOB_____

Date form started: _____

Allergies to Medications: (List name of medication as well as the type and severity of reaction to it)

_____

_____

_____

LIST OF ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription, OTC, herbal supplements, vitamins and dietary supplements. Please include medications taken only as needed.

DATE STARTED	NAME OF MEDICATION & DOSAGE	DIRECTIONS FOR USE (example: I tablet twice daily, or as needed)	DATE STOPPED	NOTES: Reason for taking/Dr. name

Signature _____ **Date** _____