COUNTRYSIDE ORTHOPAEDICS, PC

PATIENT MEDICATION LIST

FAX (703) 858-1801

Name: ______________________________ **Date:** ____________

Please complete the following sections as thoroughly and accurately as possible.

A. Drug Allergies ____

B. Please list all medications you are currently taking.

Medication	Dosage	Times/Day	Reason/Comments

B. Please list all over-the-counter medications and/or supplements you are currently taking.

Over-the-Counter/Supplement	Dosage	Times/Day	Reason/Comments

______________________________ ______________________

Patient Signature **Date**

February 2008