The Ear, Nose & Throat Surgical Associates

Patient's Name: _____

Date of Birth: _____

(Office Use Only)
Tobacco Use?
Yes No
Smoking Cessation Counseling Needed?
Yes No
Date Completed:

_____

Chart # _____

CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTION:

Please list below any medication(s) you are currently taking including:

- Prescription Medicine
- Over-The-Counter Medicine (Non-Prescription)
- Vitamins & Herbal Supplements

NAME OF MEDICINE	DOSE	HOW OFTEN
Example: Tylenol	325mg	Every 4-6 hours as needed

(Office Use Only)

REVIEWED BY: & DATE (ONCE PER VISIT)

If more space is needed, continue on reverse side:

MEDICATION LIST
PAGE 2

Patient's Name: _____ Date of Birth: _____

CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTION:

NAME OF MEDICINE	DOSE	HOW OFTEN	(Office use only) REVIEWED BY: & DATE (ONCE PER VISIT)
Example: Tylenol	325mg	Every 4-6 hours as needed	

12/30/09