KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Annual Patient Medication / Drug List

Today's Date _____

Patient Name: _____ **Date of Birth:**_____

ALL PATIENTS: This information will be held in **strict confidence** and will be used only for safe and appropriate care. Please provide the medication/drug name, the dosage you take, and the frequency of which you take the medication / drug. Please use the back of this page if you need more space.

Medications used during treatment may interact with both prescription and non-prescription drugs; including herbal supplements. These reactions may result in **SEVERE INTERACTIONS.** It is **extremely** important that you inform your provider of **any** drug you currently use or may have taken so that this may be considered in planning your treatment.

Conway's Pharmacy and **Wal-Mart of Mt. Vernon Pharmacy** are preferred by the Health Center. Most prescriptions are electronically transmitted for your convenience. Please list **Conway's**, **Wal-Mart** or another pharmacy you prefer.

Pharmacy Name: _____ ***Pharmacy Town:***_____

Medication/Drug	Dosage	How many times a day	What are you taking it for
EXAMPLE: Lisinopril	***10 mg***	***2 MORNING __ NOON ___ DINNER 2 BED***	***High blood pressure***