Georgia Breast Care

Medications

PATIENT NAME: _____ **DOB:** _____/_____/_____ **AGE:** _____ **DATE:** _____

CURRENT MEDICATIONS

☐ *CHECK HERE IF* **NONE** ***include:*** ***over-the-counter medicines, vitamins, herbals and supplements***

FOR YOUR PROVIDER TO PROVIDE THE MOST COMPREHENSIVE TREATMENT, IT IS ESSENTIAL FOR US TO HAVE A CURRENT UPDATED MEDICATION LIST ON EACH VISIT. PLEASE *DO NOT* WRITE *NO CHANGES*.

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

Name: _____ **Dosage:** _____

☐ **I take aspirin or blood thinners.**

Please specify type & dosage : _____

☐ **I take a steroid.**

Please specify type & dosage: _____

_____ _____

PATIENT OR AUTHORIZED SIGNATURE **DATE**