OUT PATIENT MEDICATION LIST

Welcome to Quantum Radiology. In order to serve you better please list the patient's MEDICATIONS with DOSE including over the counter medication, herbal, dietary supplements, drops, ointments, pumps, patches, inhalers, sprays. Also, list ALLERGIES.

Patient Name: _____ Date:_____

To be completed by the patient or responsible person before the procedure.

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE IT	COMMENTS
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

LIST ALLERGIES: (Food and Drug / Reaction)_____

Information completed by:_____ Relation to Patient:_____