UNIVERSITY Pain Clinic

PAIN MEDICATION LIST

Patient Name: _____ Date: _____

Medication Allergies: _____

_____

Please list all Prescription Medication you are currently taking. Please include all inhalers, patches, herbal and over the counter medications you use.

Medication Name	Amount	Times taken/used per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
10.		
11.		
12.		
13.		
14.		
15.		