ALIGN SPINE & PAIN

My Medications

Patient _____ Date _____

Master Medication List
List current and recent medications you take. Include over-the-counter medications, herbals, and supplements

Pain Medication List
List current pain medications you use including over-the-counter pain medications. Include past pain medications you have tried.

We are fortunate to have access to modern medicine. However, keeping track of medications and using them as prescribed is vital for effective and safe use. Our hope is that this form may improve **organization** and enhance **patient safety.**

Identifying current and past pain medications help us **tailor** and **personalize** your pain management plan.

Master Medication List			
Medication	Dose	Frequency	Currently Taking
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Pain Medication List				
Medication	Dose	Frequency	% Pain Relief	Currently Taking
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No
				Yes / No

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