Georgia Infectious Diseases, PC
5761 Peachtree Dunwoody Road
Suite # 300
Atlanta, Georgia 30342

PATIENT NAME: _____ Date of Birth: _____

MEDICATION RECORD

Please assist us with healthcare by providing complete information regarding all prescriptions and over-the-counter medications that you take. Please include all herbal remedies and vitamins as well as any type substance that is intermittently consumed or has recently been discontinued. Please be mindful that omissions may jeopardize our ability to provide you with the best possible care.

Name of medicine or substance	Dose (Total Milligrams)	How many times per day?	When taken (AM, PM, After Meals)	Who prescribed prescriptions? (M.D. Name)	Why is the medicine taken?	Describe side effects