Outpatient Ambulatory Summary

Current Medications, OTC, and Herbal Preparations List

Patient Name:_____
MR#: _____
DOB: _____

Allergies: _____
_____
_____
Latex allergy: Yes No

PCP:_____
Phone:_____

Pharmacy:_____
Phone:_____

Diagnosis Codes:_____

Date	Medication	Dose	**Frequency**	**Date Prescribed**	**Date Discontinued**

*If patient comes to clinic already on medication, then in “date prescribed” column please indicate N/A.