PARTNERS IMAGING CENTERS

MRN# _____

MEDICATION RECORD

Patient Name: _____
Last First M.

Date (i.e. 24/12/60)	Medication Name (prescriptions, over the counter, dietary etc.)	Dosage (i.e.10mg)	Frequency (i.e. Daily)	Method (i.e. oral)	Time Taken	am / pm

PATIENT HISTORY

Smoking Status:

_____ Current Everyday Smoker _____ Former Smoker

_____ Current Some Days Smoker _____ Never Smoker

Medication Allergies _____

_____

Symptoms related to your visit today _____