PREMIER
UROLOGY GROUP, LLC
Urological Surgical Associates Division

MEDICATION LIST

PATIENT'S NAME: _____ DATE:_____

PHARMACY: _____

PHARMACY ADDRESS & PHONE #: _____

ALLERGIES: _____

MEDICATION:	DOSAGE:	FREQUENCY:

PLEASE LIST ALL OF YOUR CURRENT PHYSICIAN'S:

CARDIOLOGIST:	
PULMONOLOGIST:	
OB/GYN:	
PCP:	
OTHER(S):	