Radiation Medicine
Medication List

Frederick Health

PATIENT NAME | DATE OF BIRTH / / DATE

PREFERRED PHARMACY | PHONE

PHARMACY ADDRESS | FAX

I am currently on Chemotherapy: ☐ Yes ☐ No

Include all Prescribed drugs, Over-the-counter (OTC) drugs, Herbs, Vitamins, and Supplements:

Drug name	Dose (mg)	Number of tablets/capsules taken each dose	Frequency (How Often) Taken	Date Prescribed

If you are on pain medications or steroids, who prescribed them for you? _____