**Patient and Caregivers**: Please print all the patient's medications, including prescriptions, over the counter, and herbal medications. If you need help with this list, please let us know and we will assist you. At discharge, you will receive a copy of this form from the Radiation Therapy Staff.

**Patient Name** (please print) _____

**Patient Primary Care Physician** _____

**Patient Medication List**

| Name of Medication | How often is It Taken ? | Name of prescribing Physician |
|---|---|---|
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| | | |

Do you have any allergies to any medication? Please list:

_____

_____

_____

Do you have any other allergies? Please list:

_____

_____

_____

Sign _____ Date _____