# Client Drug List


**Name:**_____

**Date:**_____

**Phone**:_____

**County:**_____ **Zip Code:**_____

**Primary Agent:**_____

***Do not list over-the-counter medications**
***Only list medications you fill at your pharmacy**

**DRUG LIST**

| Name of Prescription Medication (As it reads on your bottle) | Dose (mg) | How many times a day? | Do you receive a 30 or 90 day fill? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

(List additional medications on back)

**Do you have VA?** ___Y___N **Preferred Pharmacy**_____

**Do you have Medicaid?** ___Y___N **Current Plan** _____

**Do you receive extra help?** ___Y___N **Preferred Hospital**

**Do you prefer mail order?** ___Y___N ____Mercy ____Cox Other _____

**Primary Physician**_____

**Comments** _____

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