Patient Better®
The Medication Form

Patient Name:_____

D.O.B: _____

Pharmacy # and Prescriber	Medication & Lot #	Strength	Unit Dose	Times a Day	For Primary Diagnosis	Start Date	End Date	Known Drug Interactions

Pharmacy #	
Pharmacy Name:	
Phone Number:	
Address:	
City, State, Zip:	

Pharmacy #	
Pharmacy Name:	
Phone Number:	
Address:	
City, State, Zip:	

Pharmacy #	
Pharmacy Name:	
Phone Number:	
Address:	
City, State, Zip:	

Form filled out by: _____

Today's Date: _____