5-Hole 1/4 1 3/8 c-to-c

BAYLOR
Neuroscience Center
Headache Center
Movement Disorders Center
A Department of Baylor University Medical Center at Dallas

DATE: _____

PATIENT NAME: _____

DOB: _____

Height:	Weight:	BP:	Temp:	HR:	RR:

MEDICATIONS:

Please list all medications you are currently taking. Include all prescriptions from different physicians, over-the-counter medicines, mineral supplements and herbal medications. **If you need any refills today, please place a * by that medication in the below table.**

MEDICINE NAME	DOSAGE	SCHEDULE (how many times daily)

MEDICATION ALLERGIES: _____

Are there any new medical problems you would like to address today? _____

Have you undergone any testing since your last visit? Please explain. _____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

52672 (09/10)

HEADACHE MANAGEMENT/MOVEMENT DISORDERS CENTER MEDICATION LIST

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