NAME:_____ DOB:_____

MEDICATIONS LIST

PROBLEM	MEDICATION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

PLEASE LIST ANY MEDICATION ALLERGIES: TYPE OF REACTION:

Please complete all pages and bring to your Medicare Annual Wellness Visit

NAME:_____

BELOW PLEASE LIST ANY OTHER PHYSICIANS YOU ARE SEEING & FOR WHAT REASON

Physician:_____ Reason:_____

Address:_____

Physician:_____ Reason:_____

Address:_____

Physician:_____ Reason:_____

Address:_____

Physician:_____ Reason:_____

Address:_____

Use Note Section Below for More Detail

Patient (or Patient Representative) Signature:	Date:
Provider Signature:	Date:

Please complete all pages and bring to your Medicare Annual Wellness Visit