

MEDICATION OR SUPPLEMENT LIST

Approx. Date Started	MEDICATIONS <i>Please list diabetes medications first, including insulin, then all others</i>	Dose (mg or units)	How many pills at one time?	How often taken each day? (Once, twice, etc.)	Time of the day taken (before or with meal; etc.)	STAFF ONLY*	
						Date Changed/Stopped	Staff Initials

1. What **allergies** do you have to medicine? None Other:

2. What is your pharmacy name _____ and phone number _____ (or cross street, city)?

3. How many times a week do you miss or skip medication(s)?

4. What concerns do you have about your medication? Schedule Finances Side effects Other:

Note: This list summarizes your home medications, herbs or supplements. Changes made during your appointments at the Center for Diabetes Services are based on information provided by you, your family members, or healthcare team members. It is not meant to substitute advice given to you by your prescribing healthcare provider.

PATIENT SIGNATURE _____ **Date:** _____

*STAFF: Review each visit. Line through changed or stopped medications; enter any new or changed meds on new line.

Staff signature _____	Date: _____	Staff signature _____	Date: _____
Staff signature _____	Date: _____	Staff signature _____	Date: _____
Staff signature _____	Date: _____	Staff signature _____	Date: _____
Staff signature _____	Date: _____	Staff signature _____	Date: _____



DIABETES SERVICES
3801 Sacramento, 7th Floor
San Francisco, CA 94118
415-600-0506

PATIENT IDENTIFICATION

Your NAME _____
 Date of Birth _____