Audiology & HEARING CENTER

Cookeville – McMinnville

Patient: _____ DOB:_____ Chart:_____

As part of your hearing healthcare history, we need to know about any medications you take. Please provide the following information. Dr. Norwood or Dr. Davidson will go over this information with you when you arrive at your appointment. Please include ALL Medications. If additional space is needed, use the back of the page. If you have any questions about this form, please do not hesitate to contact our office. IF YOU HAVE A LIST OF MEDICATIONS, WE CAN MAKE A COPY AND YOU WILL NOT NEED TO FILL THIS FORM OUT

NAME & STRENGTH OF MEDICINE	DOSAGE	HOW TAKEN (circle one)
1._____	_____	Orally, Injection, Other
2. _____	_____	Orally, Injection, Other
3. _____	_____	Orally, Injection, Other
4. _____	_____	Orally, Injection, Other
5. _____	_____	Orally, Injection, Other
6. _____	_____	Orally, Injection, Other
7. _____	_____	Orally, Injection, Other
8. _____	_____	Orally, Injection, Other
9_____	_____	Orally, Injection, Other

For office use only:

Provider Signature:_____Date:_____

Information updated:_____ Provider Signature:_____