Mady & Mules
Physical Therapy Sports Rehabilitation

MEDICATION INFORMATION

Patient Name ____

☐ **I do not take any medications/vitamins/supplements.**

Pain: (List dosage/frequency)

☐ **Tylenol**	Dosage _____________	Frequency ________________
☐ **Percocet / Endocet / Tylox** (Oxycodone + Tylenol)	Dosage _____________	Frequency ________________
☐ **Dilaudid** (Hydromorphone)	Dosage _____________	Frequency ________________
☐ **Duragesic** patch (Fentanyl patch)	Dosage _____________	Frequency ________________
☐ **Hydrocodone** (Lortab/Norco/Vicodin)	Dosage _____________	Frequency ________________
☐ **MS Contin** (Morphine sulphate)	Dosage _____________	Frequency ________________
☐ **Oxycodone** (OxyContin)	Dosage _____________	Frequency ________________
☐ **Other**:_________________________	Dosage _____________	Frequency ________________

Anti-Inflammatories: (List dosage/frequency)

☐ **Advil/Motrin/Ibuprofen**	Dosage _____________	Frequency ________________
☐ **Aleve** (Naprosyn/Naproxen)	Dosage _____________	Frequency ________________
☐ **Aspirin**	Dosage _____________	Frequency ________________
☐ **Celebrex**	Dosage _____________	Frequency ________________
☐ **Mobic** (Meloxicam)	Dosage _____________	Frequency ________________
☐ **Diclofenac sodium** (Voltaren)	Dosage _____________	Frequency ________________
☐ **Prednisone and/or Steroid Pack**	Dosage _____________	Frequency ________________
☐ **Other:** _________________________	Dosage _____________	Frequency ________________

Muscle Relaxers: (List dosage/frequency)

☐ **Amrix / Flexeril / Fexmid** (Cyclobenzaprine)	Dosage _____________	Frequency ________________
☐ **Skelaxin** (Metaxalone)	Dosage _____________	Frequency ________________
☐ **Soma** (Carisoprodol)	Dosage _____________	Frequency ________________
☐ **Other**: _________________________	Dosage _____________	Frequency ________________

Vitamins/Supplements:

____	Dosage_______	Frequency _________________
____	Dosage_______	Frequency _________________
____	Dosage_______	Frequency _________________

Other Medications / Topicals / Patches:

____ ____

____ ____

List all allergies that you may have: ____

Check if you are taking any medications for conditions listed below.

☐ High blood pressure	☐ Diabetes
☐ Heart Medications	☐ Gastrointestinal
☐ Blood Thinners	☐ Rheumatology
☐ Cholesterol	☐ Other: _________________________
☐ Diuretics (water pill)	

Patient Signature:____ Date:______________________.

(if patient is a minor parent/guardian must sign)

Rev 12/18/19

Physical Therapist Reviewed: __________