Patient Name: _____ Date of Birth: _____ Date Completed: _____

PEDIATRIC UROLOGY OF WESTERN NEW YORK, P.C.

Please list **all** of the medications, herbs or vitamins that your child is taking. **If you do not know all the information, please call your pharmacy to find out.** This information is necessary for your child's visit today.

___ **Patient is on NO MEDICATION**. (Check box)

Medication	**Strength**	**Dosage**

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

12) _____

13) _____

14) _____

If you need more space, please use the back of this sheet.

Parent Signature: _____ Provider Signature: _____ Date: _____