HEARING ASSOCIATES, INC.
18433 ROSCOE BLVD. STE. 204
NORTHRIDGE, CA 91325
AUDIOLOGY & HEARING AID DISPENSING

# PATIENT MEDICATION LIST

Today's Date: ______________________________________

Patient's Name: ______________________________________

If you are unsure of your medication name,
please list *what condition* the medication is used to treat.

***IF YOU HAVE A PRE-MADE LIST, PLEASE GIVE DIRECTLY TO STAFF ***

| Name of Medication | Dosage | How Often Taken | Reason/Illness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I HEREBY ACKNOWLEDGE THAT A COPY OF
HEARING ASSOCIATES NOTICE OF
PRIVACY PRACTICES WAS MADE AVAILABLE
TO ME:

______________________________
INITIALS DATE