Northwest PRIMARY CARE

Patient Reported Medications

(Prior to Urine Drug Screen)

Patient's Name: _____ DOB: _____

Please list all controlled medications, over-the-counter medications, supplements, and herbal medications that you have taken in the last 72 hours. **Do not include other medications that have been prescribed by your PCP.**

Medication	Time of Last Dose

I have used marijuana in the last month: ☐ YES ☐ NO

I have used the following illegal drugs in the last month:

_____

_____

_____

_____

The above is true and correct to the best of my belief.

_____

Patient Signature *Date*