PARKINSON'S DISEASE PATIENT MEDICATION FORM

Patient Name: **Date of Birth:**

enter as: mm/dd/yyyy

Today's Date:

Important names and numbers:

	Relationship	10 Digit Phone Number
Care Partner	Choose	
Parkinson Doctor or Neurologist		10 Digit Phone Number
Primary Care Physician		10 Digit Phone Number
Psychiatric Physician		10 Digit Phone Number
Pharmacy		10 Digit Phone Number

Basic Information:

Year I was diagnosed with Parkinson's Disease:

I have the following conditions (check box):

☐ Anxiety	☐ Constipation	☐ Arthritis (specify)
☐ Depression	☐ Hypertension	☐ Cancer(specify)
☐ COPD	☐ Diabetes	☐ Joint Replacement (specify)
☐ Dementia	☐ Heart Disease	☐ Thyroid Disease (specify)
☐ Overactive Bladder	☐ Psychiatric care	☐ Reflux

I wear (check box):

☐ Contacts ☐ Eye glasses ☐ Dentures: ◯ full ◯ partial

☐ Hearing Aid: ◯ left ◯ right ◯ both ☐ Prosthesis (specify)

Additional Comments: Enter brief comments regarding health condition, medication, behavior or health care needs.

PARKINSON'S DISEASE PATIENT MEDICATION FORM

Patient Name: Date of Birth:

Today's Date:

List all medications being taken for Parkinson's and other medical conditions, including over-the-counter medications and supplements.

			"X" or SPECIFY HOUR if time critical					MM/YY
Medication	**Condition Treated**	**dosage**	**a.m.**	**p.m.**	**eve.**	**bed.**	**w/ food**	**started**

NOTE: Parkinson's medications *MUST* be administered ***on time, every time***.

PARKINSON'S DISEASE PATIENT MEDICATION FORM

Patient Name: Date of Birth:

Today's Date:

☐ I feel disoriented or confused today in a way that is not normal for my Parkinson's Disease.
Notes:

☐ I have a Deep Brain Stimulation (DBS) device.
Notes:

☐ I have a Duopa Pump.
Notes:

☐ I have Parkinson's Disease-related dementia.
Notes:

☐ I experience hallucinations or delusions as part of my Parkinson's Disease.
Notes:

☐ I have difficulty swallowing.
Notes:

☐ I have special dietary needs.
Notes:

☐ I get dizzy or feel faint.
Notes:

☐ I have balance issues.
Notes: