PARKINSON'S DISEASE PATIENT MEDICATION FORM

Patient Name: _____ **Date of Birth:**____/_____/_____

Today's Date: ___/_____/_____

Important names and numbers:

Care Partner Name Relationship 10 Digit Phone Number

_____ _____ _____

Parkinson Doctor or Neurologist:

Name: _____ Phone:_____

Primary Care Physician

Name: _____ Phone:_____

Psychiatric Physician

Name: _____ Phone:_____

Pharmacy

Name: _____ Phone:_____

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.

			SPECIFY HOUR if time critical					MO. / YR.
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: _____

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

			SPECIFY if time critical					MO. / YR.
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:_____

_____