THE AUSTIN CENTER
FOR
RADIATION ONCOLOGY

1020 West 34th Street

MEDICATION LOG

Patient Name_____ Date of Birth _____/_____/_____

Pharmacy Name_____ Phone #_____

Medication
Allergies_____

_____

Other Allergies (such as latex, any type of contrast, shellfish) _____

_____

Medication	Dosage	Reason for Taking

Reviewed By_____
Staff Initials