

SOUTHLAND INJURY MEDICAL CENTER, INC.

PAIN MEDICATION HISTORY

LAST NAME: _____ FIRST NAME: _____ DATE: _____

	MEDICATION	DOSAGE	# OF PILLS PER DAY	EFFECT: % PAIN REDUCTION	DATE STARTED	DATE STOPPED	SIDE-EFFECT
EX:	WATER	8 OUNCES	4	100	5/1/2006	still taking	NONE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

Please start from the most recent.