MEDICATION LIST

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (How many or how much you take.)	**FREQUENCY** (How often you take it.)	**ROUTE** (How you take it, i.e., by mouth, injection etc.)
LIST ALL OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE**	**FREQUENCY**	**ROUTE**
LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE**	**FREQUENCY**	**ROUTE**