



# Medication List

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I attest that this is the most up to date information.

Please include **ALL** prescriptions, over the counter, herbals, and vitamin/mineral/dietary supplements.

Medication Name	Dosage (25 mg, etc.)	Frequency (3x per day)	Route of Administration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_