Medication List

Are you currently taking any form of medication- including prescription, over-the-counter, herbal supplements, vitamins, or dietary supplements?

Yes_____ No_____

If you answered yes, please complete the following medication chart below, be sure to include any medications you are currently taking which includes any or all of the following: prescriptions, over-the-counter medications, herbal supplements,vitamins, or dietary supplements. Please include the name of the medication, dosage, frequency it is taken, and route of administration (oral, injection, drops, etc.).

If you already have your medications listed somewhere else, please provide us with a copy, write “see list” below, and sign and date at the bottom of this page.

Medication Name	Dosage	Frequency	Route

Patient Signature:_____ Date:_____ Date of Birth:_____