MEDICATIONS LIST

Please list below all medications currently being taken. Please include all prescription and over-the-counter medications as well as any vitamins and/or herbals.

PATIENT NAME:____ DOB:__________________

MEDICATION NAME	**DOSE** (20 mg, mcg, ml, etc.)	**FREQUENCY** (daily, twice daily, etc.)

ALLERGIES: Please list below all medication allergies

____

____

____

____

____

____