MEDICATION LIST

PLEASE LIST ALL PRESCRIPTIONS, OVER-THE-COUNTER, HERBALS, VITAMIN/MINERALS, DIETARY/NUTRITIONAL SUPPLEMENTS

MEDICATION NAME	DOSE (ie; MG)	FREQUENCY/ROUTE (ie; times per day, oral, injection)	FOR TREATMENT OF:	ORDERING DOCTOR/ DATE

This medication list is current and complete to the best of my knowledge.

Patient Signature:_____ Date: _____

Office Use: PT Initials _____