## MEDICATION LIST

**Per your insurance, please complete all required information on this form.**

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

| MEDICATION NAME | DOSE (ie; MG) | FREQUENCY (ie; times per day) | ROUTE (ie; oral, injection) | FOR TREATMENT OF: | ORDERING DOCTOR |
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This medication list is current and complete to the best of my knowledge.

Patient Signature:__________________________________________________________ Date: ____________________________

Office Use: PT Initials _____