

MEDICATION LIST (ALL PATIENTS)

NAME: _____ DOB: _____

Please be sure to include ALL prescription drugs, over-the-counter drugs, vitamins and herbal supplements.

	What I'm Taking	Form <i>(pill, injection, liquid, patch, etc.)</i>	Dosage	How Much & When	Use <i>(regularly or occasionally)</i>	Start/Stop Dates <i>(11/5/15 - 3/10/16 or 11/5/15 - ongoing)</i>	Notes, Directions, Reasons for Use
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