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** *(pill, injection, liquid, patch, etc.)*	**Dosage**	**How Much & When**	**Use** *(regularly or occasionally)*	**Start/Stop Dates** *(11/5/15 - 3/10/16 or 11/5/15 - ongoing)*	**Notes, Directions, Reasons for Use**
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