Medication List

Patient Name: _____ **Date:** _____

PRESCRIPTION MEDICATIONS:	**DOSAGE:**	**FREQUENCY:**	**ORAL:**	**INJECTION:**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
OVER THE COUNTER MEDICATIONS:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
VITAMINS/MINERALS:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
OTHERS MEDICATIONS:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____