MEDICATIONS LIST

Please list below **all medications** currently being taken. Please include all prescription and over-the-counter medications as well as any vitamins and/or herbals.

PATIENT NAME:_____ DOB:_____

MEDICATION NAME	**DOSE** (20 mg,mcg,ml,etc.)	**FREQUENCY** (daily, twice daily,etc)

ALLERGIES: Please list below all medication allergies

_____

_____

_____

_____