



## MEDICATION LIST

PATIENT NAME (LAST, FIRST, MI) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Please include all prescriptions and over-the-counter medications, including herbal products and vitamins. Please update the form before every physician visit.

	<b>Medication</b>	<b>Dose</b>	<b>How Often</b>
1			
2			
3			
4			
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