MEDICATION LIST

PATIENT NAME:_____ DOB:_____

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

NAME OF MEDICATION	DOSAGE (HOW MUCH)	FREQUENCY (HOW OFTEN)

MEDICATION LIST COMPLETED BY:_____ DATE:_____

MEDICATION LIST REVIEWED BY:_____ DATE:_____

MEDICATION LIST REVIEWED BY:_____ DATE:_____

MEDICATION LIST REVIEWED BY:_____ DATE:_____