LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

PATIENT: _____ DOB: _____ DATE: _____

PRESCRIPTION NAME INCLUDING OVER THE COUNTER MEDS (VITAMINS, HERBALS)	DOSAGE (MG, ML)	FREQUENCY (ONCE DAILY, TWICE DAILY)	ADMINISTERED ROUTE (ORAL, SUBLINGUAL, INJECTABLE, TOPICAL)

PHARMACY: _____ PHONE #:_____