MEDICATION LIST

Please list all medications (prescribed and over-the-counter including vitamins and herbs) you are currently taking (correctly spelled). We need the dosage, how often and the prescribing physician's name. Also, list any special instructions the medications may require. **USE EXTRA PAPER IS NEEDED**.

Mail or fax us a copy if you have a list or just bring it in with you and we can make you a copy.

Also, keep a list for you in an easy to find location like your purse or wallet.

Patient's Name: _____

Date: _____

Medication	Dosage/Mg	Times per day	Prescribing Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

SPECIAL INSTRUCTIONS _____

_____

_____