

Medication List

Patient Name: _____

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:

Patient Signature: _____ Date: _____