

Medication List for: (Please Print) _____

Date: _____

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:
		<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: _____

Reviewed by: _____

Date: _____