Medication List

Please provide a list of All medications and dosages, including vitamins,herbs, and over the counter medications. If you don't have a list you can ask your pharmacy to print one, or fill this one out. Please bring this list to each appointment. ***If you have a printed list, you do not need to fill this out.***

Patient name: _____
Date: _____

Medication (including vitamins and herbs, over the counter medications)	Dose	Frequency	Purpose