Name: ______________________________
DOB: _____________
Date: ______________

List of Current Medications

If you have a separate list of your medication, please bring the printed list to your appointment. Skip and go to the next page.

List all **prescription** medications FIRST, then all tablets, patches, drops, ointments, injections, etc.
Also list any medication you take only on occasion (like Viagra, Albuterol, Nitroglycerin).

Medication (Brand & Generic Name)	Dose	Reason for taking Medication	How often do you take this medication	How do you take this medication	Start Date (mm/dd/yyyy)	Prescriber
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		
				☐Injection ☐Oral ☐Topical		

Over the Counter Products: ☐ Vitamins ☐Over the Counter Pain Relievers ☐ Diet Supplements ☐Herbal

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