List of Medications

Patient Name: _____ DOB: _____ Initial Update Date: _____

Please list all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin, etc).

Medication (brand and/or generic name)	Dose	How often do you take this medicine?	Reason for taking?	Started when?	Stopped when?	Who prescribed it?

Check here if using additional pages ☐

Patient Signature: _____

Practitioner Signature: _____