



Medication List

Please take the time to fill out **all** the information

<u>Name:</u>	<u>Dose/Mg:</u>	<u>Directions:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements or Vitamins:

<u>Name:</u>	<u>Dose/Mg:</u>	<u>Directions:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications to which you are allergic:

Patient Name:

Date: