Name:_____ Date:_____

Medication (prescription, OTC)	Dose	Frequency	Route (oral, inj, etc.)

Supplement/Vitamin/Herb	Dose	Frequency	Route	Reason for taking

LIST OF CURRENT MEDICATIONS

List all medications you are currently taking (tablets, patches, drops, ointments, injections, etc.). Include prescription, over-the counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like albuterol, nitroglycerin).