Name:_____ **DOB:**____/____/____ **Today's Date:**____/____/____

CURRENT MEDICATION LIST

If more space is needed, please use the backside.

Medication	Strength	How Often Taken	Reason for Taking Medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Vitamins & Supplements	Strength	How Often Taken	Reason for Taking Medication
1.			
2.			
3.			
4.			
5.			

ALLERGIES TO MEDICATIONS: _____ Check here if NO Allergies

Medication	What is your reaction to this medication?
1.	
2.	
3.	
4.	
5.	