MEDICATION LIST

Please list all medications prescribed by your physician(s), including over-the-counter and supplements. Also include any ointments, injections, liquids, inhalers and any medications taken on occasion.

PATIENT NAME: _____ Date of Birth: _____ Date updated: _____

Name of medication	**Dosage** (mg, mL, units, etc.)	**Frequency** (How often?)	**Reason for taking**	**Directions**	**Start & stop date**	**Taking as directed?** (Yes or No)	**Prescribing doctor**