Medications List

Name:_____ Date:_____

Please list ALL medications (including prescription, over-the-counter, herbal supplements, and vitamin/mineral/dietary supplements). **Include the drug name, dosage, frequency, and route.**

Drug Name	Dosage	Frequency	Route
			Oral Injection Drop Topical Other_____
			Oral Injection Drop Topical Other_____
			Oral Injection Drop Topical Other_____
			Oral Injection Drop Topical Other_____
			Oral Injection Drop Topical Other_____