MEDICATION LIST NAME_____________________________________ DATE_____________

Please list all medications (prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements). Include the dosage, frequency, and purpose and administration method.

Medication	**Dosage**	**Purpose**	**Frequency**	**Method of Administration**
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other:
			○ As Needed ○ Once daily ○ Twice Daily ○ Three Times Daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Injection ○ Other: