Your Medication List

Name: _____

Date: _____

Thank you for taking the time to fill out your forms. So we can give you the best of care, please list below all medications, prescriptions and over the counter medicine, why you are taking them and the prescribing Doctor. Also list all vitamins, minerals and supplements that you are taking.

Please list all your doctors (medical and dental) with phone numbers. It helps us greatly in expediting your care.

Prescription Medication	Dose	Reason	Prescribing Doctor

Over The Counter Medication	Dose	Reason	Frequency

Physicians Name	Address	Phone Number

Thank you