PATIENT NAME	DATE OF BIRTH	TODAY'S DATE

CURRENT MEDICATION LIST

Please list any medications that you take (prescriptions and over-the-counter, including vitamins and supplements).

NO CURRENT MEDICATIONS ☐

MEDICATION NAME	DOSE (mg)	HOW MUCH DO YOU TAKE AT ONE TIME? (pills, units, tsp)	HOW OFTEN / WHEN DO YOU TAKE? (1x day, am/pm, with meals)
example: Motrin	200 mg	3 pills	2 x day as needed