

MEDICATION LISTING

Please list ALL medications you take, along with the dose and associated information.

Patient Name: _____

Medication Name	Dose (mg)	Taken how often	Route	Reason for taking	Currently taking
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No
			<input type="checkbox"/> oral <input type="checkbox"/> topical <input type="checkbox"/> injection		Yes No

Reviewed

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____