Documentation of Current Medications

Patient Name:_____ Date of Service: _____

Please list all medications:
Prescription Medications
Over-the-Counter Medications
Herbals
Vitamin/Mineral/Dietary Supplements

Do you currently use Tobacco? _____
If yes, how much?_____

Do You have any Allergies to any medications? Please list:_____

Name of Medication	**Dosage** (mg or ml)	**Frequency** (how often?)	**How Do You Take This Medication?** (oral, injection, inhaler, eye, topical, aerosal)

Additional Dates of Service - Medication List Review & Updated as Appropriate

Date of Service: _____ **Date of Service: _____**

Date of Service: _____ **Date of Service: _____**