Medication List

Medications Provided by Patients Primary Care Physician/Specialist

INCLUDE Over the Counter and Supplements

Patient Name: _____ DOB: _____

Allergies: _____

*****Please list your medications, as well as any Over the Counter Meds or Supplements taken**

Medication/Strength	How Taken	Medication/Strength	How Taken

Healthcare Provider History

List of other Providers/Physicians that you are actively seeing:

Providers Name	What do you see them for?