

Please list **ALL** Medications, Vitamins and Supplements you are currently taking. Include Prescription medications and Non-prescription or Over-the-counter medications [Tylenol, Aspirin, Motrin, Tums, Nyquil, decongestants, antihistamines, etc.] **and** any vitamin, mineral and herbal supplements. Write the names of your medications in the left column below, the dosages in the middle column, and the related medical conditions in the right-hand column. You can also tape the label from your prescription receipt onto this form.

Your Name _____

Date Last Updated: _____ Updated by: _____

| Medication Name | Dosage (How much you take) | Condition (What you take it for) |
|-----------------|-------------------------------|-------------------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Page 1.

Continue on the reverse side as

needed.

