PATIENT NAME:			DOB:	DATE:
	MEDICATION LIST			
	Please list all prescription medications as well as vitamins and supplements that you are currently taking			
DATE STARTED MEDS	NAME OF MEDICATION	DOSE - mg, mcg, iu	How Often & When Do You Take	REASON-why are you taking this
Jan 2010	*EXAMPLE: Lisinopril*	*10 mg*	*one tablet at bedtime*	*high blood pressure*
Feb 1999	*EXAMPLE: Lantus Insulin*	*10 units*	*with each meal*	*diabetes*