Patient's Name: ______________________ Date: __________________

Please list all your medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements, and the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:

		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Sublingual ○ Topical ○ Subcutaneous injection ○ Other:
		○ As Needed ○ Once daily ○ Twice daily ○ Three times daily ○ Other:	○ Oral ○ Injection ○ Other:

By my signature below, I certify that the information I have provided above and/or on a separate document is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: ___________________________ Date ______________

Patient/Legal Guardian Name: ____

Reviewed by:_________________________________ Date: _________________________