Current Medication List

*Must include medication name, dosage, frequency, and route of administration to **satisfy insurance requirements***

Patient Name: ______________________________ Date: ________________

Name	Dosage	Frequency (circle one)	Route (circle one)
Prescription Medication:			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
Over the Counter Medication (Advil, Aleve, etc.):			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: ________

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Name	Dosage	Frequency (circle one)	Route (circle one)
Vitamin/Mineral/Dietary Supplements (Multivitamins, Vitamin C, etc.):			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
Herbals (Echinacea, Saw Palmetto, Gingko Biloba, etc.):			
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________
		1x/day 2x/day As needed Other:________	Oral Topical Injection Other: _________