MEDICATION LIST

Patient Name: **Healthcare Provider:**
Allergies: **Date completed:**

MEDICATIONS Generic/Brand	REASON FOR USE	DOSE	HOW OFTEN I TAKE IT	MORNING	NOON	EVENING	BEDTIME	**Special Notes/Instructions** ***Please review the accompanying medication information sheets for more details. Please call your pharmacy if you have any questions regarding your medications.

OVER-THE-COUNTER/ HERBALS Generic/Brand	REASON FOR USE	DOSE	HOW OFTEN I TAKE IT	MORNING	NOON	EVENING	BEDTIME	**Special Notes/Instructions** ***Please review the accompanying medication information sheets for more details. Please call your pharmacy if you have any questions regarding your medications.