

# Medication List

**Date:** \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Chart** \_\_\_\_\_

Help us care for you better by telling us what prescriptions and over-the-counter medications you take. Please update this every time you visit.

<b>Prescriptions</b>					
Name of Medicine	Dose	How many times a day?	When do take it? (Morning and night, after meals)	Prescribed by what Doctor?	Reason for taking this drug

<b>Over-the-counter medications, herbal remedies, vitamins, etc.</b>					