# MEDICATION LIST

PATIENT NAME ______________________________________ DATE _______________________

Please list all medications you are currently taking. Include all prescriptions, over the counter medications, herbals, vitamins, minerals and dietary supplements as well as dosage, frequency and administration method for each medication.

If you have a list, please bring with you to your evaluation or use the following form to gather the information.

| **MEDICATION** | **DOSAGE** | **FREQUENCY** | **METHOD OF ADMINISTRATION** |
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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 NAME (Printed) PATIENT SIGNATURE DATE

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PARENT/GUARDIAN NAME (Printed) PARENT/GUARDIAN SIGNATURE RELATIONSHIP

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REVIEWED BY DATE