



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 |
|------------|--------|--|--|
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed | <input type="checkbox"/> Oral |

| | | | |
|--|--|--|--|
| | | <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other: | <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> 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: _____