**MEDICATION LIST**

**Name _____ Today's Date _____**

**Date of Birth _____**

**Please list all medications that you are currently taking: prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements.**

| Medication | Strength (mg, etc.) | How Many | How Taken (orally, injection, etc.) | How Often | Doctor's Name | Reason |
|---|---|---|---|---|---|---|
| ***EXAMPLE: ASPIRIN*** | ***81 MG*** | ***1*** | ***BY MOUTH*** | ***ONCE DAILY*** | ***SMITH*** | ***PREVENT STROKE*** |
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Rev. 10/25/2018