List All Medicines You Are Currently Taking: (Please fill out medications, dosages prescribed with and how many times a day. Also include Herbs, Vitamnins, Minerals, and any other Supplements).

Medication	Dosage	# Times a day	Reason for medication (e.g. High Blood Pressure)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Patient Name________________________________ **Signature** __________________________**Date** ___________