MEDICATION RECORD

To ensure that we have ALL of your medications recorded in your medical record please list them below. Include any over the counter drugs, vitamins/nutritional supplements, herbal and homeopathic remedies.

Name:_____ DOB:_____

Allergies: _____

Medication	Dose	Frequency	Reason (I.e. blood pressure, diabetes, etc.)

Please update as needed. Print and present to each of your healthcare healthcare providers at each visit.