Drug Medication(s) List

Instructions to the Patient – Please fill out this form completely. Make sure you put the required information in each column. Include all of the prescription and non-prescription medications (over the counter) you are using daily or on an as needed basis. (Please do not list Nutritional Supplements here, they will go on the back of this form)

Name ____ **Age:** ____________ **Date** ______________ **Weight** ____________________

Drug Allergies: ____ ☐ **NKDA**

Name of Drug or Medication	Strength or Dose Per Capsule or Tablet	# of Times Taken Per Day	How Long on This Drug?	Condition Prescribed For?	Name of Doctor That Prescribed This Drug
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Nutritional Supplement(s) List

Instructions to the Patient – Please fill out this form completely. Make sure you put the required information in each column. Include all of the nutritional supplements you are using daily.

Name ______________________________ **Age:** __________ **Date** ___________ **Weight** ________________

Drug Allergies: ____ ☐ **NKDA**

Nutritional Supplement Name	Strength or Dose Per Capsule or Tablet	# of Times Taken Per Day	How Long on This?	Name of Doctor That Prescribed? If none put NA
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				