***MEDICATION* LIST/ even over the counter medications**

NAME: _____
DATE: _____

**Medication:** **Dosage:** **How Often:**

1. _____
2 _____
3 _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

ALLERGIES: _____

_____

_____

NO KNOWN DRUG ALLERGIES: _____

PATIENT SIGNATURE: _____