



# Medications and Supplements

Name \_\_\_\_\_ Date \_\_\_\_\_

List of Prescription Medications	Strength / Dosage	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Non-Prescription Drugs / Vitamins / Supplements:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Known Medication Allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Entered into EHR \_\_\_\_\_ Date Entered \_\_\_\_\_