# MEDICATION LIST

| Name: | Date: |
|---|---|

**(Include Over the Counter Meds & Supplements)**

| Name of Medication or Supplement (vitamin, calcium, etc) | Dosage | Frequency/Directions | Route (oral, IV, injection) | Physician Prescribing | Condition |
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***Please complete with N/A and still sign and date the document even if you don't take any medications.**

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**Client Signature / date**