# MEDICATIONS

**Patient Name**_____ **Date**_____

Please list your current medications including all **medications, over the counter medications, herbal and vitamin/mineral/dietary (nutritional) supplements** you are currently taking. *Route is the method the medication is administered e.g. **oral, injected, intravenous, nasal, eye, ear, suppository or other.**

| Drug Name | Dosage | Frequency | Route* | Therapist Use only |
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