List of Medications

Please list all current medications you are taking, include all over the counter medications, vitamins and herbal supplements.

□ **I am not currently taking any medications, vitamins or herbal supplements**

□ **I will bring in the list with me**

Name of drug and strength of drug	How often and when do you take this drug	Administered Route
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________
		☐Mouth ☐Under Tongue ☐Injection ☐Topical ☐Other ________________