MEDICATIONS LIST

Patient Name: _____ Date: _____

What prescription medications do you now use?

Prescription Medication Name	Dosage (mg, etc)	Frequency (daily, every 6 hrs, as needed, etc)	For what condition?

What over the counter medications, nutritional supplements, homeopathic remedies, and herbs do you now use?

Supplement Name	Dosage (mg, etc)	Frequency (daily, every 6 hrs, as needed, etc)	For what condition?

What dental homecare products (toothpaste, mouthwash, floss, oral irrigator, etc) do you now use?

Product Name	Frequency (daily, twice daily, occasionally, etc)