Please list your medications, supplements, vitamins, and any over-the-counter drugs below. Complete the **name, dosage, frequency, the route taken, and how long you have been on this dosage** of the medication. Print as many copies of this form as you need. Thank you!

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Dosage** | **Frequency (circle all that apply)** | **Route (please circle)** | **On this dose since (best guess, if unknown)** |
| **Example:****Metformin** | **500mg, 2 tablets** | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** | **Dec 2021** |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |
|  |  | **1x 🞄 2x 🞄 3x 🞄4x****Every other 🞄 Day 🞄 Week** **Month 🞄 As Needed** | **Eye 🞄 By mouth****Topical 🞄 Inhaled****Injection 🞄 Vaginally 🞄 Rectally** |  |