PATIENT NAME_____

Medication List

Please write in the spaces below all medications you are currently taking including over the counter meds including any herbals. We also ask that you include the strength and how you take your medications.

Name of Medicine	Strength	Directions how you take this med	For Physician Use

Date	Updated by (patient/legal guardian signature)	Date	Reviewed by Physician (Physician Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Stephenville Medical and Surgical Clinic PA
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