Medications & Supplements

Please List All Of The Following:

Prescription Medications

Over The Counter Medications

Vitamins & Minerals

All Other Supplements

Herbs

Please provide *Name of Prescription or Supplement*, the *Dose*, *How Often* you take it, *How Long* you have been taking it, and *Who* started you on it (a doctor or yourself).

EXAMPLE

	Name of Prescription or Supplement	Dose	How often	How Long	Who
Ì	Vitamin C	500mg	1 x day	1 year	(Dr. or Self)

Medications & Supplements

Name of Prescription or Supplement	Dose	How often	How Long	Who
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Medications & Supplements (continued)

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