Yorba Linda Physical Therapy Current Medication List Report

Patient Name: _____ **Date:** _____

List all the prescription Medications you are currently taking

	Name of Medication	Dosage (how many or how much you take)	Frequency (how often do you take it)	Route (how do you take it ie: by mouth, injection etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

List all over the counter medications

	Name of Medication	Dosage (how many or how much you take)	Frequency (how often do you take it)	Route (how do you take it ie: by mouth, injection etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

List all Herbals, Vitamins, Minerals, Nutritional Supplements

	Name of Medication	Dosage (how many or how much you take)	Frequency (how often do you take it)	Route (how do you take it ie: by mouth, injection etc)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				