NYGI

Medication List

Name: _____ Date: _____

Please list all prescribed medications and dosages that you are currently taking.

Medication Name	Dose (i.e. mgs)	Number of times per day	Last taken

Please list all the over the counter supplements you are taking.
Including aspirin, vitamin, mineral and herbal supplements

Medication Name	Dose (i.e. mgs)	Number of times per day	Last taken