

Name: _____

Date: _____

Please list all medications you are taking that are prescribed by your doctor(s):

Name of Medication	Dosage	Prescribing Doctor	Reason Taking	How long taking?

Please use additional sheets if necessary

Please list all medications you are taking that you purchase over-the-counter (i.e., aspirin, cough syrup, decongestants, etc), or from another source (i.e. alternative therapies, folk healer, shaman, curandera, curandero, friend). Please use additional sheets if necessary.

Name of Medication	Dosage	Where do you get this medication?	Reason Taking	How long taking?

Please use additional sheets if necessary