

## Patient Medication Form

<b>Prescription Medications</b> <u><b>NAME</b></u>	<u><b>Dosage mg/g</b></u>	<u><b>Frequency:</b></u> 1 x a day 2 x day 3 x day	<u><b>Route of Administration:</b></u> Oral, anal, injection, etc.
<b>Over the Counter</b> <u><b>NAME</b></u>	<u><b>Dosage</b></u>	<u><b>Frequency</b></u>	<u><b>Route of Administration</b></u>
<b>Vitamins, Herbals, Supplements</b> <u><b>NAME</b></u>	<u><b>Dosage</b></u>	<u><b>Frequency</b></u>	<u><b>Route of Administration</b></u>