## **MEDICATION QUESTIONNAIRE**

	DOB:	DATE:_	2/18/2021
Do you take any prescription and/or over the counter medications?   Yes   No			
below:			
Type of Medication (Over the counter or Prescription)	Dosage (# of milligrams/ ounces)	Frequency (How many times per day or per week)	Route of Administration (oral, injection or topical)
			8
PG		2	ec
			105
	and/or over the co on and/or over the o Type of Medication (Over the counter or	and/or over the counter medications on and/or over the counter medication  Type of Medication   Dosage (# of (Over the counter or milligrams/	and/or over the counter medications?   Yes   on and/or over the counter medication, please list each reconstruction  Type of Medication  Osage (# of  Over the counter or  milligrams/  many times per