MEDICATION QUESTIONNAIRE

PATIENT NAME: _____ . . _____ DOB: _____ DATE: 2/18/2021

Do you take any prescription and/or over the counter medications? ☐ Yes ☐ No

If you do take any prescription and/or over the counter medication, please list each medication below:

Medication Name	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)