ID Number: _____

Client Medication List

Please include prescribed medications, over the counter medications, vitamins, herbs, and supplements.

Name:				Date of Birth:	
☐I Take No Medication					
Date Started Medication	Name of Medication	Dose (mg, mcg, iu)	How often and When Do You Take	Reason- why are you taking the this	Who Prescribes the medication?
Jan 2010	***EXAMPLE: Lisinopril***	***10mg***	***One tablet at bedtime***	***High Blood Pressure***	