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PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### LIST OF CURRENT MEDICATIONS / SUPPLEMENTS

(You may also provide this information in a typed Word document or similar format)

Name of Medication / Supplement	Brand	Date Started	Dosage (MG)	Quantity/ Frequency	Time of Day
(Example) omega-3	Nordic Naturals EPA- extra	1/1/15	1000 MG/ TSP	2 TSP/ day	With breakfast
(Example) fluconazole	Diflucan	1/15/15	100 MG tablet	1 tablet/ day	At bedtime