BEYOND WELLNESS

Medication List

Patient Name: _____

DOB: ___/___/_____ **Height:** _____ **Weight:** _____

Please list ALL medications including prescription, over the counter, herbals, vitamins & supplements.

	Medication Name	**Dosage & Frequency**	**Route of Administration** (Oral, Nasal, Injection, etc.).
1.			
2.			
3.			
4.			
5.			
6.			
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11.			
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16.			