

## Patient-Reported Medications & Supplements

Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

**Please provide a complete list of all prescribed medications and supplements you are taking.**

Medication & Strength	Arising	Brkfst	Betw <-->	Lunch	Betw <-->	Dinner	Bedtime	Comments
Ex: Drug Name _____ mg		1		1			1	

Supplement & Strength	Arising	Brkfst	Betw <-->	Lunch	Betw <-->	Dinner	Bedtime	Comments
Ex: Sup. Name _____ units		1				2		