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Please list your medications, supplements, and vitamins below. Complete the **name, dosage, frequency, the route it's taken, and how long you have been on this dosage** of the medication. Print as many copies of this form as you need. Thank you!

Name	Dosage	Frequency (circle all that apply)	Route (please circle)	On this dose since (Best guess, if unknown)
Example: Metformin	500 mg, 2 tablets	1x • 2x • 3x • 4x Every other • Day • Week Month • As Needed	By mouth • Eye Topical • Inhaled Injection • Vaginally	Dec 2021
		1x • 2x • 3x • 4x Every other • Day • Week • Month • As Needed	By mouth • Eye Topical • Inhaled Injection • Vaginally	
		1x • 2x • 3x • 4x Every other • Day • Week • Month • As Needed	By mouth • Eye • topical • inhaled • injection • Vaginally	
		1x • 2x • 3x • 4x Every other • Day • Week • Month • As Needed	By mouth • Eye • topical • inhaled • injection • Vaginally	
		1x • 2x • 3x • 4x Every other • Day • Week • Month • As Needed	By mouth • Eye • topical • inhaled • injection • Vaginally	
		1x • 2x • 3x • 4x Every other • Day • Week • Month • As Needed	By mouth • Eye • topical • inhaled • injection • Vaginally	
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		1x • 2x • 3x • 4x Every other • Day • Week • Month • As Needed	By mouth • Eye • topical • inhaled • injection • Vaginally	
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