Orthopedic Physical Therapy Associates LLC

Medication List for: ____________________________

Date: ____________________________

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration for each medication.

Medication	Dosage	Frequency	Method of Administration
		☐ As Needed	☐ Oral
		☐ Once daily	☐ Sublingual
		☐ Twice daily	☐ Topical
		☐ Three times daily	☐ Subcutaneous injection
		☐ Other:	☐ Other:
		☐ As Needed	☐ Oral
		☐ Once daily	☐ Sublingual
		☐ Twice daily	☐ Topical
		☐ Three times daily	☐ Subcutaneous injection
		☐ Other:	☐ Other:
		☐ As Needed	☐ Oral
		☐ Once daily	☐ Sublingual
		☐ Twice daily	☐ Topical
		☐ Three times daily	☐ Subcutaneous injection
		☐ Other:	☐ Other:
		☐ As Needed	☐ Oral
		☐ Once daily	☐ Sublingual
		☐ Twice daily	☐ Topical
		☐ Three times daily	☐ Subcutaneous injection
		☐ Other:	☐ Other:
		☐ As Needed	☐ Oral
		☐ Once daily	☐ Sublingual
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		☐ Other:	☐ Other:

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