

«Clinic Name»
 «Clinic Address»
 «Clinic Address2»
 «Clinic City», «Clinic State»
 «Clinic Zip»



Phone: «Clinic Phone»
 Fax: «Clinic Fax»

Medication and Precautions List for «Client Full Name»
Date: «Create Date»

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

Medication	Dosage	Frequency	Method of Administration
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:
		<input type="checkbox"/> As Needed <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> Three times daily <input type="checkbox"/> Other:	<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous injection <input type="checkbox"/> Other:

Precautions

Please check below:	Additional Description:
<input type="checkbox"/> Abnormal Blood Pressure	

<input type="checkbox"/> Balance Problems or Dizziness	
<input type="checkbox"/> Bowel or Bladder Control Problems	
<input type="checkbox"/> Cancer History	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease or Stroke	
<input type="checkbox"/> Lung or Respiratory Problem	
<input type="checkbox"/> Neurologic Disease	
<input type="checkbox"/> Pregnancy	
<input type="checkbox"/> Recent Surgery	
<input type="checkbox"/> Weight Bearing Restrictions	
<input type="checkbox"/> Please describe any other serious medical issues not mentioned above:	

Patient or Guardian Signature	Date
Reviewed By	Date