Jacksonville Physical Therapy

MEDICATION LIST

Name:_____ Date: _____ Primary Doctor: _____

List All Allergies (Medication, Food, or Skin Sensitivities)

Allergic to:	**Describe reaction:**

List All Prescription Medications, Over-The-Counter Medicines, Herbal Supplements or Vitamins You Take

Name of Medicine & Strength (ex. mg, units)	**How to take:** (ex: take 1 tablet by mouth 2x daily)	**Why are you taking this medicine?** Or comments: