

**TUCKAHOE ORTHOPAEDIC ASSOCIATES, LTD.
PATIENT MEDICATION FORM**

PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Please list any prescription drugs, over-the-counter medications, herbal supplements and vitamins that you currently take:

Prescription Drugs

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over-the-Counter Medications

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Herbal Supplements

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____