DERMATOLOGY ASSOCIATES, INC

MRN:_____

Date: _____

Patient Name:_____

DOB:_____

# CURRENT MEDICATION LIST

**Please include all prescriptions, over the counter medications, vitamins, supplements, etc.**

| Name of Medication | Strength | Pill/tablet | Liquid | Injection | Frequency | Prescribing Physician |
|---|---|---|---|---|---|---|
| Sample | 20 mg | X | | | 2 times/day | Dr. Sample |
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If you need more room, please put additional medications on the back.