North Naples Physical Therapy

Patient Medication List

Name_____ Date:_____

Prescription Medication Name	Reason for taking	Dose (How much)	Frequency (How often)

Over the Counter Medication	Reason for taking	Dose (How much)	Frequency (How often)

Herbs, Vitamins, Etc….	Reason for taking	Dose (How much)	Frequency (How often)

List Allergies To Medicine	Type of reaction