CRAVEN
PHYSICAL THERAPY & SPINE

Name: _____ Date: _____

List of Current Medications below or please attach a list if you have one already documented

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over the counter, and supplements. Also list any medicine you take only on occasion (albuterol, nitroglycerin).

Medication	Dose	Frequency (1 x day, 2 x day, as needed etc..)	How (oral, topical, injection, under tongue)