BRUNSWICK PHYSICAL THERAPY
70 SOUDER ROAD
BRUNSWICK MD 21716

MEDICATION LIST

Date completed:_____
Date updated:_____
Date updated:_____

Name:
DOB:

List all Allergies

Allergic to:	Describe reaction

List All Prescription, Over-The-Counter, Herbal Supplements or Vitamins You Take (Use Page 2 if needed)

Name of Medication	Strength (ex. mg, mcg…)	How is it taken (ex: mouth, cream, shot)	How often do you take the medicine (once daily, twice daily, as needed)	Why are you taking this medication?

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