Name:_____ **DOB:**_____ **Date:**_____

Medication Log

Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

Rx Name	Reason for Rx	Dosing w/ time of day	Start Date	Stop Date

Supplement Log

Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

Supplement name	Brand Name	Dosing w/ time of day	Start date	Stop date