Orthopaedic Rehab Specialists, P.C.

Patient Medication List

Name: Date of Birth: Account No: Date:

	Name (Over the counter, herbal meds, vitamins)	**Dosage**	**Times taken per day**	**Route** (Ex: by mouth)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Please inform your therapist of any medication changes. Thank you!