NORTHLAND AUDIOLOGY & Hearing Services

Improve Your Hearing…Improve Your Life!

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LIST OF CURRENT MEDICATIONS

Patient Name: _____ Date of Birth: _____
First, Middle Initial, Last

As part of the *National Quality of Care Initiative*, we need to have records of your current medication list. Please list all of your medications, including prescription medications, over-the-counter medications, supplements, vitamins, and herbs.

Medication Name	**Dosage**	**Frequency** *Times per day & time of day*	**Delivery Method** *Oral, injection, patch, etc.*