# MEDICATION LIST

**Name: _____Date:_____Date Updated:_____**

| Physician's Name: | Clinic Name: | Clinic Phone |
|---|---|---|

Do you have any allergies? Yes No
Please list:

Are you taking any medications or drugs? Yes No

Vitamins, herbals, supplements, and/or over the counter medicines? Yes No

| Please list: | Strength | Frequency | Reason | Date Started | Date Ended | Causes Dry Mouth ? |
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Signature:_____