FoothillsENT
ALLERGY & HEARING CENTER

PRESCIPTION MEDICATION & OVER-THE-COUNTER SUPPLEMENT LIST

Pt. Name _____

		DOSAGE		
		Strength, How often, Route		
(ie. Amoxicillin)	*(ie. Aleve, Fish Oil)*	*(ie. 10 mg)*	*(ie. 2x)*	*(ie. Oral)*
Prescription	Supplement	S	O	R

Date Reviewed & Initialed (for office use)											