Prashanti Clinic

Existing Medication List

Please list all medications you are currently taking and who prescribes them.
If you do not take any medicines, vitamins, herbal remedies or over the counter drugs, Please state that.

Name : Male/Female: Age: Date:

	Name Of Medicine and strength	Dosage	Frequency Daily /Weekly / on need basis	Started this medicine - Year	With meal or empty stomach	Advised by (doctor name, Specialization)	Remarks
1							
2							
3							
4							
5							
6							
7							
8							