

William D. Payne D. M. D.

My Medication List

Name: _____

Please list below all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication Name	Dose (mg, drops, etc.)	When Taken (daily, at bedtime, etc.)	Reasons for Taking (blood pressure, diabetes, etc.)

Allergies and Reactions (please describe):
