(15) CURRENT MEDICATIONS, HERBS OR SUPPLEMENTS

What medications, herbs, supplements are you currently taking?
Please include significant remedies that you have stopped *taking, including birth control and hormone replacement therapies.*

Substance	Over-the-counter ***(OTC)*** Prescription? ***(Rx)***	Herb/Drug/ Vitamin?	Prescribed by? ***(Self, MD, other)***	For what purpose?	For how long?	What dosage?	What have the benefits been ?

*PATIENT NAME:*_____

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