Performing Arts Physical Therapy
The Pilates Studio® of Los Angeles

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Medication List

Please list all current medications you are taking including prescription medications, over-the-counter medications, vitamins, and dietary supplements.

Patient name: _____ **Date:** _____

Medication Name	Dosage (Amount?)	Frequency (How often?)	Time of Day (i.e. AM, PM)	How do you take medication? (i.e. by mouth, patch, injection)