Performing Arts Physical Therapy
The Pilates Studio of Los Angeles

Medication List

Patient Name_____ **Date** _____

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

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)