Voytik Center for Orthopedic Care

Medication List

Patient Name:_____ DOB:_____

****MEDICATIONS to include herbals, nutritional supplements and over-the-counter drugs.********

Medications	Dosage	Times a Day	Oral/Topical/Injection

****If there are changes to your medications please make changes above. Date and initial below indicating our list is accurate****

Patient Signature: _____

Date:	Initial:	Date:	Initial:	Date:	Initial:

Providers Signature: _____ Date: _____