South Shore Speech, Language and Swallowing Disorders, PLLC

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Phone: 631-669-7098 Fax: 631-669-3736

PATIENT MEDICATION INFORMATION

Name of Patient: _____

DOB: _____

Date: _____

Please list all current medications to the best of your knowledge and ability. This list must include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medications' name, dosage, frequency and route of administration

Name of Medication	Dosage	Frequency	Time of Day Medication is Administered