ONSPOT DERMATOLOGY

Today's Date _____

Medications:

Please list all current medications including prescriptions, over-the-counter medications, vitamins, minerals and supplements. If not currently on medications, write NONE or N/A.

☐ Please check box and do not fill out medication list if you have been seen in the last six months and you gave us your medication list at that time and your medication list has not changed.

Name of prescribed medication	Dose	Route	Frequency

Over the counter medication	Dose	Route	Frequency

Patient Name: _____ DOB: _____