THE SPINE INSTITUTE

MEDICATIONS LIST

Prescription / Over-The-Counter

Patient Name: _____

Date: _____/_____/_____ **Date of Birth:** _____/_____/_____ **Chart #:**_____

Drug Name	Strength	How Taken	How Often
EXAMPLE: Celebrex	*100mg*	*orally*	*one time a day*
EXAMPLE: Advair	*250/50*	*inhaled*	*two times a day*

Signature:_____

FORM #35