THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY
& DENTAL CLINICS

Name: _____

Date: _____ **Date of Birth:** _____

MEDICATIONS

Instructions for Patients: Enter all of the prescription and over-the-counter medications you are currently taking. Complete only the first four columns. Do not list dietary supplements or herbal medicines.

Name of medication	Dosage	Times a day it is taken	What is it taken for?	Date Medication Started	For Clinic Use Only