TEXAS SPINE & NEUROSURGERY CENTER
MEDICATION LIST

PATIENT:_______________________________ **DATE:___________________**

Please include all prescribed & over the counter medications, vitamins and dietary supplements.

MEDICATION	DOSE	HOW OFTEN	HOW TAKEN	PRESCRIBING PROVIDER
TAMINS/DIETARY SUPPLEMEN	**DOSE**	**FREQUENCY**	**HOW TAKEN**	**PRESCRIBING PROVIDER**