

# SUPPLEMENTS

For:

Non-prescription Meds: (Vitamins, Herbals, OTC, etc.)	Reason for Taking Supplement	Dosage (How Much)	Frequency (How Often/Times Per Day)	Prescribing Dr. Name	Special Notes (Take Before Meals or On an Empty Stomach, etc.)	Start (ST) Discontinue (DC) Date
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\* For information security, keep printed copy in a secure location and use password protection when saving the PDF document.

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