

## TMD Medication List

**Patient Name:**

**Date:**

**Prescription Name:**

Date of Prescription:

Reason for prescription:

Doctor Name:

Pharmacy Name and telephone:

**Prescription Name:**

Date of Prescription:

Reason for prescription:

Doctor Name:

Pharmacy Name and telephone:

**Prescription Name:**

Date of Prescription:

Reason for prescription:

Doctor Name:

Pharmacy Name and telephone:

**Prescription Name:**

Date of Prescription:

Reason for prescription:

Doctor Name:

Pharmacy Name and telephone:

**Prescription Name:**

Date of Prescription:

Reason for prescription:

Doctor Name:

Pharmacy Name and telephone: