

ALL MEDICATION CURRENTLY TAKING

(INCLUDING VITAMINS, SUPPLEMENTS AND OVER THE COUNTER DRUGS)

PATIENT'S NAME _____ **DOB** _____

TODAY'S DATE _____

DRUG ALLERGIES/REACTIONS _____

| PLEASE LIST ALL MEDS YOU ARE CURRENTLY TAKING | DOSE (mg) | # PILLS | TIMES TAKEN PER DAY | DATE MEDICATION STOPPED |
|---|-----------|---------|---------------------|-------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

OFFICE USE ONLY - LAST UPDATED (INITIAL AND DATE)

