

Patient: _____

Birthdate: _____

Date _____

LIST ALL MEDICATIONS, ETC TAKEN AT THIS TIME:

Name	PRESCRIPTION DRUGS Strength	Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OVER THE COUNTER MEDICATIONS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HERBS, FOOD SUPPLEMENTS, NEUTRACEUTICALS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

VITAMINS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____