

Patient Name _____ Date of Visit _____

ALLERGIES

Please list all medication, food, or environmental reactions:

_____	Reaction:	_____
_____	Reaction:	_____
_____	Reaction:	_____

MEDICATIONS

Please list all medications (prescribed and over-the-counter), vitamins, supplements that you take, including dose and timing. Please list on separate sheet if more space is needed.

<u><i>Name of medication</i></u>	<u><i>Dose (mg)</i></u>	<u><i>How often and when taken</i></u>
<i>Example: Lasix</i>	<i>10mg</i>	<i>Once daily with breakfast</i>

1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____
6	_____	_____
7	_____	_____
8	_____	_____
9	_____	_____
10	_____	_____
11	_____	_____
12	_____	_____
13	_____	_____
14	_____	_____
15	_____	_____
16	_____	_____
17	_____	_____
18	_____	_____
19	_____	_____
20	_____	_____