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Patient Name:_____ **Pharmacy Name & Address:**

_____

_____

Help us care for you better by telling us what prescriptions, over-the-counter medications, vitamins, supplements, or diet aids you take. We will update this every time you visit.

IF NOT CURRENTLY TAKING ANY MEDICATIONS, PLEASE MARK THE BOX BELOW that says *No Current Meds*, otherwise fill out your medications in the chart below indicating name, dose, how many times per day..etc.

□ No Current Meds

Medications, vitamins, supplements, etc.			
Name of Medicine	**Dose**	**How many times per day?**	**Who prescribed it? (Physician's Name)**

IF YOU HAVE NO DRUG ALLERGIES, PLEASE MARK THE BOX BELOW that says *No Known Drug Allergies*, otherwise indicate your drug allergies in the chart below.

□ No Known Drug Allergies

Medication Allergies	
Name of Medication	**Allergy (reaction they cause)**

Revised 5/30/10