Name: _____ Date: _____

Please list all medications you are currenlty taking (Prescribed and Over-the-counter):

Medication Name:	***Strength (mg)***	***How often you take each day:***
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		
11)		
12)		
13)		
14)		
15)		

Allergies to medication:

Medication	***Reaction:***
1)	
2)	
3)	
4)	