Please list all prescription medications you are taking

Name: _____Date:_____

[ ] I am not taking any prescription medications

Brand Name / Generic Name	**Strength (ie 10mg) Dosage (number of pills)**	**Frequency (times / day)**	**How Taken (oral, injection, patch...)**	**Date Started**
	Mg, #	/day		
	Mg, #	/day		
	Mg, #	/day		
	Mg, #	/day		
	Mg, #	/day		
	Mg, #	/day		
	Mg, #	/day		
	Mg, #	/day		

Please request another sheet if needed

Please list allergies to any medications

[ ] I am not aware of any medication allergies

Medication Name	**Reaction Date**	**Reaction You Experienced**

Please request another sheet if needed