

M E D I C A T I O N S

Name _____ **Date** _____

Please list all medications you are currently taking:

Medication	Dosage	Reason/Condition
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all supplements (vitamins, minerals, herbs) you are taking:

Please list the amount and frequency you consume:

Substance	Amount	Frequency
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Alcohol _____

Tobacco _____

Coffee _____

Recreational Drugs-Type _____