Name: _____ Date: _____

Current Physicians

Primary Care Doctor Name: _____

Other Doctor #1 Name: _____

Other Doctor#2 Name: _____

Current Medication List

You do NOT need to indicate the prescribing physician or detailed dosage info
Please include Over The Counter Medicines or Supplements that you take

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16._____

Allergies/Sensitivity to Medications

❑ NKDA – I have no known drug allergies.

❑ YES – I am allergic /sensitive to: _____