Patient Name

Medication History

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Medication History

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Drug/Food Allergies

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)
		/
		/
		/
		/