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| **Preferred name:\_\_\_\_\_\_\_\_\_\_\_ Legal name (if differs): \_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_****THIS IS A LIST OF THE MEDICATIONS THAT I TAKE**BRING THIS LIST OF MEDICATIONS TO YOUR APPOINTMENT |
| **MEDICATION NAME*****CHECK YOUR MEDICATION BOTTLES AND LABELS FOR THIS INFORMATION*** | **MEDICATION STRENGTH** | **HOW MUCH DO I USE OR TAKE AT ONE TIME OR PER DOSE?**  | **HOW DO I TAKE OR USE THE MEDICATION?**  | **HOW OFTEN DO I TAKE THE MEDICATION?** | **WHY DO I TAKE THIS MEDICATION?** |
| --HERBALS --EYE DROPS--PRESCRIPTIONS --INHALERS--SUPPLEMENTS --VITAMINS--OVER-THE-COUNTER MEDS OR MEDS PURCHASED WITHOUT A PRESCRIPTION -- ETC | EXAMPLE:# MG, # UNITS, #MCG, MG/ML ETC | EXAMPLE:2 TABLETS, 1 TEASPOON, 1 PATCH, 2 SPRAYS, ETC | EXAMPLE: BY MOUTH, APPLY TO THE SKIN, INSERT INTO THE RECTUM, ETC. | EXAMPLE: ONCE A DAY, TWICE DAILY, EVERY 4 HOURS, ONLY WHEN I NEED IT, ETC | EXAMPLE: FOR PAIN, FOR MY HEART, FOR MY BONES, ETC |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
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| 12. |  |  |  |  |  |
| 13. |  |  |  |  |  |
| 14. |  |  |  |  |  |
| 15. |  |  |  |  |  |
| **HAVE YOU TAKEN ANY MEDICATIONS THAT HAVE CAUSED PROBLEMS LIKE RASHES, UPSET STOMACH, BLEEDING, MUSCLE PAIN, OR OTHER SIDE EFFECTS.** **LIST THE NAME OF THE MEDICATION AND THE PROBLEM IT CAUSED:** |
| **WHAT PHARMACY DO YOU USE?**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DO YOU HAVE INSURANCE TO HELP PAY FOR YOUR MEDICATIONS?* YES: NAME OF INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* NO

**HOW MUCH DO YOU WEIGH?** WEIGHT IN POUNDS = \_\_\_\_\_\_\_\_\_\_\_\_\_ LBS. |