Medications

Are you currently taking any drugs or medications? Please mark "yes" or "no" yes no

Please mark "yes" or "no" for each of the following:

Antibiotics	yes	no	Blood Pressure Medication	yes	no	Steroids	yes	no
Anticoagulants	yes	no	Cortisone	yes	no	Tranquilizers	yes	no
Antidepressants	yes	no	Heart Medication	yes	no	Vitamins	yes	no
Aspirin	yes	no	Hormones	yes	no			
Birth Control Pills	yes	no	Insulin	yes	no			

Please list all prescribed medication you are now taking:

Drug	Dosage	Frequency	Reason

Patient Signature/Responsible Party: _____ Date: / /

(STOP HERE) ****SEE BELOW TO UPDATE CHANGES IN MEDICATIONS**

Are you currently taking any drugs or medications? Please mark "yes" or "no" yes no

Please mark "yes" or "no" for each of the following:

Antibiotics	yes	no	Blood Pressure Medication	yes	no	Steroids	yes	no
Anticoagulants	yes	no	Cortisone	yes	no	Tranquilizers	yes	no
Antidepressants	yes	no	Heart Medication	yes	no	Vitamins	yes	no
Aspirin	yes	no	Hormones	yes	no			
Birth Control Pills	yes	no	Insulin	yes	no			

Please list all prescribed medication you are now taking:

Drug	Dosage	Frequency	Reason

Patient Signature/Responsible Party: _____ Date: / /

Are you currently taking any drugs or medications? Please mark "yes" or "no" yes no

Please mark "yes" or "no" for each of the following:

Antibiotics	yes	no	Blood Pressure Medication	yes	no	Steroids	yes	no
Anticoagulants	yes	no	Cortisone	yes	no	Tranquilizers	yes	no
Antidepressants	yes	no	Heart Medication	yes	no	Vitamins	yes	no
Aspirin	yes	no	Hormones	yes	no			
Birth Control Pills	yes	no	Insulin	yes	no			

Please list all prescribed medication you are now taking:

Drug	Dosage	Frequency	Reason

Patient Signature/Responsible Party: _____ Date: / /