Clear Form

CURRENT MEDICATIONS

Record prescriptions, over-the-counter medicines, vitamins, herbs and supplements you currently take.

Name:

Pharmacy/Location: Phone:

Rx Allergies/Reactions:

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects (Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects (Frequency/Duration/Severity)

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Reactions and Side Effects (Frequency/Duration/Severity)

DRUG NAME	DATE STARTED	FREQUENCY AND DOSAGE	REASON TAKING	PRESCRIBED BY

Reactions and Side Effects (Frequency/Duration/Severity)

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PAST MEDICATIONS

Record prescriptions, over-the-counter medicines, vitamins, herbs and supplements you no longer take.

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

DRUG NAME	DATE STARTED/STOPPED	FREQUENCY AND DOSAGE	REASON	PRESCRIBED BY

Reactions and Side Effects
(Frequency/Duration/Severity)

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(Frequency/Duration/Severity)

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Reactions and Side Effects
(Frequency/Duration/Severity)

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