Patient Name: _____

Please list all prescription and over the counter medications, vitamins, and natural supplements.

Medication List: (Medication name, strength, and how you take this medication)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Do you have any drug allergies? Yes / No

If yes, please list: _____

_____

Name of your pharmacy, phone number (MUST PROVIDE)_____

_____

Height: _____ Weight: _____

Are you a smoker? Yes / No

If yes how often & approximate year you started: _____

PLEASE PROVIDE YOUR EMAIL ADDRESS SO WE CAN BETTER ASSIST YOU IN YOUR MEDICAL

CARE: _____