

# Medication History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Allergies: \_\_\_\_\_

## Prescribed Medications

Please indicate what prescribed medications you are currently taking. Use back of page if you need more space to list your medications.

Date First Taken	Medication	Dosage	Quantity	Frequency	Doctor Who Prescribed	Date Last Taken

## Over-the-counter Medications, Herbs and Supplements

Please indicate what over-the-counter medications you are currently taking, including all dietary, herbal supplements, and smoke cessation products. Use back of page if you need more space to list supplements.

Date First Taken	Medication/Supplement	Dosage	Quantity	Frequency

Are your supplements helping? \_\_\_\_\_ If so, how? \_\_\_\_\_