

## **MEDICATION LIST**

Have there been any changes to your medication since your last visit? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ Yes \_\_\_\_\_ NO

*If yes, please list your reaction while taking the medication:*

*Allergic to:* \_\_\_\_\_ *Reaction:* \_\_\_\_\_

*Allergic to:* \_\_\_\_\_ *Reaction:* \_\_\_\_\_

*Allergic to:* \_\_\_\_\_ *Reaction:* \_\_\_\_\_

*Allergic to:* \_\_\_\_\_ *Reaction:* \_\_\_\_\_

*Please list any and all medications that you are currently taking and what you are taking them for:*

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

*Medication:* \_\_\_\_\_ *Taken for:* \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_