Please fill in all fields with complete information. It is important that the information is readable and complete including Dosage, how often medication is taken per day, etc. You may want to keep a copy of this for your own records.

VITAL STATISTICS

Patient Name: _____ **Date:** _____

Height: _____

Weight: _____

Smoking Status:
- ☐ **Current every day**
- ☐ **Current some days**
- ☐ **Former smoker**
- ☐ **Never smoked**

(Blood Pressure will be taken in the office)

Blood Pressure: Systolic: _____ **Diastolic:** _____

ALLERGIES TO MEDICATIONS

Use the chart below to list all medications, both prescription and non prescription that you are allergic to. As an example: Penicillin reaction: rash, hives etc….

Medication Name	Type of reaction such as a rash or breathing difficulties

PRESCRIPTION MEDICATIONS

Use the chart below to list ALL the brand-name and generic prescription medications you currently take. Be sure to fill in ALL the information for each medication. The dosage appears on each pill bottle on the prescription label in milligrams (mg).This is called the dose, or strength. The label on liquids and shots list the dose too. Use the back of this sheet or additional pages for additional medications.

Medication Name	Prescribing Doctor	Reason for taking the medication	Dose (such as 2 mg, 1 tsp)	How Often? (such as 2x/day)

Use the chart below to list ALL the brand-name and generic prescription medications you currently take. Be sure to fill in ALL the information for each medication. The dosage appears on each pill bottle on the prescription label in milligrams (mg).This is called the dose, or strength. The label on liquids and shots list the dose too. Use the back of this sheet or additional pages for additional medications.

Medication Name	Prescribing Doctor	Reason for taking the medication	Dose (such as 2 mg, 1 tsp)	How Often? (such as 2x/day)

NONPRESCRIPTION MEDICATIONS, VITAMINS AND SUPPLEMENTS

List all those that you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin, fish oil or other nutritional supplements. Include any herbs or alternative medicines you take. Please fill in all the fields!

Name	Reason for taking the medication	Dose (such as 500 mg)	How Often? (such as 2x/day)