Medications/Allergy list

Today's Date:________________________ Patient Name:________________________________

Medications currently taking:

Medication	Date Started Taking	Dose	Frequency
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________
____________________	________________	_____	_________

Medication Allergies:

Medication/allergen/agent	Reaction to Allergy
____	____
____	____
____	____
____	____

Supplements/Vitamins Currently Taking:

____

____

____

____

____

Enter if known:

Height: ________ ft. __________in.
Weight: ________ lbs.
Bp: Systolic _____ /Diastolic_____ Pulse: _____
Bp in: Right or Left arm

Are your experiencing any of these symptoms?

Check All that apply:

- Stiff, sore joints
- Headaches
- Heartburn
- Gas Pain – Bloating
- Constipation – Diarrhea
- Restlessness – Sleeplessness
- Food / Environmental Allergies