List of Current Medications

Complete to best of knowledge, list all tablets, patches, drops, ointments, injections. Include prescription, over-the-counter, herbal, vitamin and diet supplement products. Also list any medicine you take on occasion.

Last Name	First Name	Client #	DOB(MM/DD/YY)	Height	Weight	Pharmacy Name and Phone #

Date of Last Flu Shot (MM/DD/YY):_____

Allergies (please describe reaction)

If **No Medications** Taken Regularly Check Here and sign below ☐

LIST BELOW ALL: Prescription Medications, Non-Prescription, Herbal and Vitamins, Medications taken on occasion. *Note you may attach the "Prescriptions Label" portion of your most recent blister pack.*

Medication Name (Brand & Generic Name)	Strength	How Much & How Often Taken	Reason for Taking

This list is complete to the **best** of my knowledge.

Signature: Date (MM/DD/YY):

Additional pages attached ☐

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