Name:_____ DOB: _____

List or attach a copy of all medication you are currently taking (including prescriptions, birth control, over-the-counter, vitamins):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Medication allergies □ YES □ NO If yes, list:

1. _____
2. _____
3. _____

Patient or Guardian Signature	Date	(Office Use Only) Reviewed by MA:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____