



Medication Form:

Are you taking or have you recently taken any prescriptions or over the counter medicines? If so, please list all, including vitamins, natural or herbal prescriptions and/or diet supplements:

Medication Name:

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

Health History Update and Patient Initials:

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |