Patient Drug & Allergy Information

Name: _____ Date of Birth: _____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____
- ☐ _____

***Are you currently* taking any medications?**

- ☐ Not currently prescribed any medications

Medication _____ _____ mg

Medication _____ _____ mg

Medication _____ _____ mg

Medication _____ _____ mg

Medication _____ _____ mg

Are you currently taking any over the counter medications

- ☐ Not currently taking any OTC medications

Medication _____ _____ mg

Medication _____ _____ mg

Medication _____ _____ mg

Are you currently taking any over vitamins or supplements:

- ☐ Not currently taking any Vitamins or supplements
- ☐ Supp/Vitamin: _____ _____ mg
- ☐ Supp/Vitamin _____ _____ mg
- ☐ Supp/Vitamin _____ _____ mg

Please list you family physician and all physicians who are prescribing you medications:

_____

_____

_____