

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:
