

Name: _____

DOB: _____

Updated Medications

What medications are you currently taking? (Please list any herbal medicines and supplements)

<u>Name</u>	<u>Purpose</u>	<u>Amount</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____

Please list all known medical allergies and describe reaction.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Are you diabetic? YES or NO

Have you ever had a blood transfusion? YES or NO

Do You have history of blood clots? YES or NO

Pharmacy _____ Pharmacy Phone number _____

Pharmacy Address _____