Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

DRUG	PRESCRIBED FOR:	HOW LONG
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

DRUG	PRESCRIBED FOR:	HOW LONG
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all vitamins/herbs supplements you are currently taking. Also, list how much of each supplement you are taking.

VITAMIN / HOW MUCH	
_____	_____
_____	_____
_____	_____
_____	_____

Check the following items which apply to you and indicated the amount used:

□ Coffee _____
□ Tea _____
□ Soft Drinks _____
□ Artifical Sweetner _____
□ Antacids _____
□ Laxatives _____
□ Candy _____
□ Ice Cream _____
□ Alcohol _____
□ Cigarettes _____
□ Other Tobacco Products _____

How many desserts do you have in an average week? _____