Name_____ Date: _____/_____/_____

Please list all medications, including aspirin, over-the-counter medications, vitamins and home remedies.

Medication/Strength/Dosage	Reason for Taking

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **YES** ☐ **NO**

If yes, please list:

Medication	Reaction

If your medication or allergy list is too long to fit on the page, bring in a list for us to copy!