Name: _____ Date: _____

MEDICATION FORM: Please fill out this form with all the medications you take.
Example: prescriptions, samples, vitamins, nutraceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents, radioactive meds, respiratory therapy-related meds, parental nutrition, blood derivatives and IV solutions, and any product designated by the FDA as a drug.

MEDICATION	DOSE	HOW OFTEN	WHAT DRUG IS USED FOR

Do you have any specific health or dental concerns today? YES / NO
If yes, please explain: _____

Have you been hospitalized since your last visit here? YES / NO
If yes, please explain: _____

Do you regularly take any type of vitamin(s)? YES / NO
If yes, explain: _____

Patient Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____