Current Medications

Patient:_____ Chart #_____ Date of Visit_____

Please list all current medications including drug dose and how often you take them. Please include both prescriptions and over the counter medications. Also include any eye drops or cream or ointment. Please include the approximate date that prescription medications were started, the doctor's name who prescribed them, and the reason why you are taking the medications, such as hypertension or diabetes.

Any Beta Blockers? YES NO **CAN YOU TAKE DECONGESTANTS? YES NO**

Date of last antihistamine pill/eye drop/or nasal spray taken:_____

Prescription Medications	Date Started	M.D. Prescribing	Reason for Medication

Over the Counter Medications	Reason for Medication

Drug Allergy	Drug Intolerance
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)