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Personal Medication Record

Complete the information below and bring it with you to your appointment.

Name: _____ Date:_____/_____/_____ (MM/DD/YY)

Height (in): _____
Weight (lbs): _____

List all prescriptions, over-the-counter medications, vitamins, and herbal supplements you are taking:

Medication	Strength	Reason for taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(*Please continue list on back side of this sheet if you require more space.)*

Please list any allergies:	What was your reaction?
1.	
2.	
3.	
4.	

(*Please continue list on back side of this sheet if you require more space.)*

Are you allergic to rubber or latex?

☐ YES ☐ NO

_____
Patient's Signature (If 18 or older)

_____ _____
Parent, Guardian, or Responsible Party Signature Relationship to patient