

Patient Name _____ Date _____

YOUR MEDICATIONS

(If you have a list of your medications, please give it to the receptionist to copy for your records.)

Are you currently taking any vitamins, minerals, or supplements? Yes No

Please list: _____

Are you currently taking any medications? Yes No

Please list your medications:

Anti-inflammatory (Aspirin, Ibuprofen, Motrin, etc.) _____

Pain / Analgesics: _____

Muscle relaxants: _____

Blood pressure pills: _____

Corticosteroid: _____

Other: _____

Are you allergic to any medications? Yes No

Please list: _____

In the past, have you ever used any of the following?

Birth control pills

Corticosteroids