

**LIST OF MEDICATIONS, SUPPLEMENTS, AND TOPICAL PREPARATIONS**

**Patient Name (PRINT**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

Please list all prescription and over the counter products. Include frequency of use (once daily, for example), and dosage. Attach additional pages if necessary. Thank you!

Please list any environmental, seasonal, food, and drug allergies or sensitivities: