MEDICATIONS, HERBAL AND OTHER SUPPLEMENTS

Patient Name:_____ Date:_____

Are you presently taking any of the following medications?

Yes	No	Analgesics (Aspirin, Ibuprofen, Naproxen Sodium)	Dosage_____Frequency_____
Yes	No	Cardiovascular Agents (Digoxin, Lanoxin, Captopril)	Dosage_____Frequency_____
Yes	No	Laxatives	Dosage_____Frequency_____
Yes	No	Antacids (Bicarbonate of Soda, Calcium Carbonate)	Dosage_____Frequency_____
Yes	No	Sedative, Antianxiety, Antipsychotic Drugs (Lithium, Thioridazine, Chlorpromazine, Prozac)	Dosage_____Frequency_____
Yes	No	Anti-Inflammatories (Prednisone, other corticosteroids, NSAIDs)	Dosage_____Frequency_____
Yes	No	Respiratory Agents (Theophylline)	Dosage_____Frequency_____
Yes	No	Diuretics (Lasix)	Dosage_____Frequency_____
Yes	No	Antibiotics	Dosage_____Frequency_____
Yes	No	Elixirs containing sorbitol (Theophylline, Acetaminophen)	Dosage_____Frequency_____
Yes	No	Insulin or Diabetic Pills	Dosage_____Frequency_____
Yes	No	Sleeping Pills	Dosage_____Frequency_____
Yes	No	Thyroid Medication	Dosage_____Frequency_____
Yes	No	Blood Thinning Pills	Dosage_____Frequency_____
Yes	No	Seizure Medication	Dosage_____Frequency_____
Yes	No	Weight Reducing Pills	Dosage_____Frequency_____
Yes	No	Birth Control Pills	Dosage_____Frequency_____
Yes	No	Hormones	Dosage_____Frequency_____
Yes	No	Blood Pressure Pills	Dosage_____Frequency_____

List any other (including over the counter) medications you are currently take/use_____
_____

Please list any Herbal, or other natural supplements, vitamins and minerals you are taking:_____
_____

Do you feel the herbal, natural supplements are helping you?_____

Are you allergic to any medications, natural supplements, or over the counter medications? Yes____ No_____

If Yes, please name and describe the reaction:_____

_____