Medication List

Preferred Pharmacy: _____

Allergies to Medications:

_____

_____

_____

Allergic to Shellfish / Seafood: ❒ Yes ❒ No

Allergic to Latex: ❒ Yes ❒ No

List Medications in Non-Shaded Area Below

MEDICATION NAME	DOSAGE	HOW OFTEN DO YOU TAKE THIS MEDICINE

REVIEW OF SYSTEMS

HAVE YOU HAD OR CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING:

Wear Glasses ..... ❒ Yes
Wear Contact Lenses ..... ❒ Yes
Hearing Loss ..... ❒ Yes
Shortness of Breath ..... ❒ Yes
Chest Pain ..... ❒ Yes
Swelling in feet/ankles ..... ❒ Yes
Heart Murmur ..... ❒ Yes
Pacemaker ..... ❒ Yes
Defibrillator ..... ❒ Yes
Abdominal Pain ..... ❒ Yes
Constipation ..... ❒ Yes
Diarrhea ..... ❒ Yes
Loss of Appetite ..... ❒ Yes

Weight Loss ..... ❒ Yes
Weight Gain ..... ❒ Yes
Back Pain ..... ❒ Yes
Joint Pain ..... ❒ Yes
Leg Cramps ..... ❒ Yes
Seizures ..... ❒ Yes
Tremors ..... ❒ Yes
Headaches ..... ❒ Yes
Dizziness ..... ❒ Yes
Excessive Thrist ..... ❒ Yes
Depression ..... ❒ Yes
Bruises Easily ..... ❒ Yes
Bleeds Easily ..... ❒ Yes