MY MEDICATION LIST

Patient Name: _____ **Date:** _____

Date of Birth: _____

Please list all drugs you are currently taking. Drugs include prescription and over-the-counter medications, herbal products, nutritional supplements, and recreational drugs. ***Bring this list with you to your first appointments.***

Name of Drug	Strength of Drug	How often do You take	Why are you Taking this?	Prescribing Doctor

Do you have any allergies? _____Yes _____No

If Yes, Please list; _____
_____
_____

I declare that there have NOT been any changes to my Medications since my last visit to MFAC.

Patient Signature:_____ **Date:**_____