CURRENT MEDICATION, VITAMIN, AND SUPPLEMENT LIST

Name: _____ Emergency Contact Name/Phone: _____

Relationship to patient: _____

Date last updated/initials: _____ _____ _____ _____

Name of medication	Strength/Dose	Frequency	Condition medication is treating	Notes

Marijuana/Cannabis use: Yes ____ No ____ Frequency: _____

Form: Edible/beverage _____ Smoke/vape _____ Topical _____

History of antibiotic therapy: Yes ____ No ____ Date last taken: _____

History of cortisone/steroid therapy: Yes ____ No ____ Date last taken: _____

Are you taking any blood thinning medication? Yes ____ No ____

Allergies to medication, vitamin, supplement

Name of medication	Reaction caused by medication

Patient Signature _____ Date _____

Office Witness _____