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Medicines & Allergies

Name
Signature
Date

Pharmacy - Local
Address
Phone # ( )
Fax # ( )
Pharmacy - Mail

Please print carefully and include all of the information requested. Use two sheets if necessary.

Be sure to record all medicines you are currently taking, including vitamins, supplements and over-the-counter (OTC) medications.

Don't forget to include pharmacy contact info above and list your allergies at the bottom of the page.

Prescriptions, Over-the-Counter (OTC), Supplements and Vitamins

Medicine Name	Brand or Generic?	Dosage	How & when is drug taken?	Prescribed or OTC? If prescribed, include name of prescribing doctor*	Side effects or reactions?

ALLERGIES: _____

This information must be updated at each appointment.

Please turn page for Intake Form