PERSONAL MEDICATION RECORD									
Complete the information and bring it with you when you come for your appointment. Thank you!									
Date:	Name:								
Height:	Weight:								
List all prescription medications, over-the-counter medications, vitamins and herbal supplements that you are taking. List all prescribing									
phsycians. At the end, please answer the questions dealing with what you are allergic to. Thank youl									
Medication	Physician (last name, first name)	Strength (of med eg., 10 mg)	Time	Time .	Time	Time	Time	Total Strength for this medica tion	Reason for taking this medication?
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