Patient name sticker

Date: _____

MEDICATION LOG

Are you allergic to any medications? Please list here:

Name of Medication

Are you currently taking any medications? Please list here:

Name of Medication	Strength

Please list what conditions are being treated with the above medications? _____

_____

_____

Family Doctor: _____

What do you weigh? _____ How tall are you? _____ Are you allergic to latex? _____

If female, are you pregnant or nursing? ___ Do you use birth control? ___ Type _____

Do you or a member of your family have a history of melanoma or other skin cancer? _____

Do you take blood thinners or aspirin? _____ Occupation _____

Do you or any blood relatives have hay fever or allergies to pollen or animals? _____

Do you or any blood relatives have asthma or eczema? _____

Have you had any other medical problems in the past? _____

_____

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