Patient Name:_____

Date:_____

PLEASE LIST EACH AND EVERY VITAMIN, FOOD SUPPLEMENT, HEALTH FOOD PRODUCT, AND MEDICATION (BOTH PRESCRIPTION AND NON-PRESCRIPTION) THAT YOU USE IN THE SPACES PROVIDED BELOW. In addition, please include the dosage/strength of each product (e.g. 1mg, 400 iu, etc.), the number of times a day/week you take the product, and the amount of each product that you take at one time (e.g. 1 pill, 1 Tablespoon, 2 drops, etc.).

IT IS IMPARITIVE THAT YOU COMPLETE THIS FORM THOROUGHLY AND NEATLY AS IT WILL BECOME PART OF YOUR PERMANENT RECORD.

PRODUCT NAME	BRAND NAME	DOSAGE/STRENGTH PER PILL	# OF TIMES TAKEN PER DAY/WEEK	AMOUNT TAKEN AT A TIME
MEDICATIONS:				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
VITAMINS/SUPPLEMENTS:				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				