Medications, Supplements, Allergies, & Other Providers Information

Please take a few moments to complete this intake form prior to your appointment. Thank you!

Name ____ Date of Birth _______________

Allergies:____

Your Primary Care Physician, Name and Phone Number:

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Specialty Providers, Name and Phone Number:

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Medications:

Medication	Dose	Frequency	Reason Taking / How long taking	Prescribing Provider

Name ______________________________ Date of Birth ______________

Supplements:

Supplements	Dose	Frequency	Reason Taking / How long taking	Prescribing Provider

Over the Counter Medications: (examples: Ibuprofen/Tylenol/Sinus Medication/Sleep Medication, etc.)

OTC	Dose	Frequency	Reason Taking / How long taking	

Name ______________________________ Date of Birth ______________

Please list any Surgeries with Year of Surgery

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Please list any additional medical history information you would like to provide.

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