Medication History:

Please indicate all medications you are taking at this time, include over-the-counter and vitamins and similar products

Name	Dose (mg)	Number of tablets	Frequency per day	Reason or disease	Length of use months, years	Has it helped you? Yes, No

Past Medical History:

Please fill in the circle in front of any disease that you have or had in the past:

Hypertension	0	Stomach ulcers	0	High cholesterol or triglycerides	0
Diabetes	0	Colitis or Crohn's disease	0	Cancer:_____	0
Heart disease	0	Other stomach problems	0	Leukemia	0
History of a heart attack	0	Bad headaches or migraines	0	Anemia	0
Other heart diseases	0	History of a stroke	0	Depression	0
COPD	0	Seizures	0	AIDS or HIV	0
Asthma	0	Other neurological disease	0	Psoriasis	0
Other lung diseases	0	Goiter or thyroid problems	0	Tuberculosis	0
Reflux	0	Other endocrinologic disease	0	Blindness or glaucoma	0

Please describe any other disease not previously indicated:_____

_____

Previous Allergies to Medications:

Please tell us of previous allergies to medications and the type of reaction you had: _____

_____