Medication Form

Name:_______________________________________ Date Completed:____________________________
Address:_____________________________ City:________________ State: ________ Zip: _______________
Phone Number:__________________________________ Birth Date:______________________________
Emergency Contact/ Phone:____
E-Mail ____
(Notification of sales, specials, and new products and services will be sent by e-mail.)

Allergies and Drugs to Avoid/Adverse Reactions:
____
____

Please list any other special dietary information and foods or ingredients you avoid. (ex: vegan, no gluten, etc.)
____
____
____

Current Medications:

List all medications, supplements, hormones and over-the-counter products you are currently taking.
Include the brand/manufacturer's name for supplements, hormone creams and over-the-counter products.

Name:____ Dosage:________________________
Reason for Taking:_______________________________ Directions:______________________________
Date Started:______________________________ Date Discontinued:______________________________

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Patient Name:____

Name:____ Dosage:__________________________
Reason for Taking:_____________________________ Directions:___________________________
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Immunization Record:
(Include dates administered)
☐ Tetanus_______________ ☐ Pneumonia Vaccine_______________ ☐ Flu Vaccine_____________________
☐ Hepatitis Vaccine_________________ ☐ Other____

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