MEDICATIONS / ALLERGIES

Current Medications Include vitamins and/or herbal products		
Name of medication	**Dose**	**Frequency**

Known Allergies:		
Medicine (i.e. penicillin, etc)	**Environmental** (i.e. latex, iodine, etc)	

Medical History Please list dates of each instance.		
Major Medical Problems (ie. Diabetes, Heart Problems, etc)	**Surgeries** (Please list approximate dates)	**Hospitalizations** (Please list approximate dates)