Current Medications

(please include over the counter medications)

Patient Name: _____ **Date of Birth:_____**

	Name of medication	Dosage/ Frequency	Is the medication working?	Length of medication use
1.	_____	_____	**Circle one** Y / N / Maybe	_____
2.	_____	_____	**Circle one** Y / N / Maybe	_____
3.	_____	_____	**Circle one** Y / N / Maybe	_____
4.	_____	_____	**Circle one** Y / N / Maybe	_____
5.	_____	_____	**Circle one** Y / N / Maybe	_____
6.	_____	_____	**Circle one** Y / N / Maybe	_____
7.	_____	_____	**Circle one** Y / N / Maybe	_____
8.	_____	_____	**Circle one** Y / N / Maybe	_____
9.	_____	_____	**Circle one** Y / N / Maybe	_____
10.	_____	_____	**Circle one** Y / N / Maybe	_____