Name (Please Print) ____

List all medications and supplements you are taking.	FOR OFFICE USE ONLY Type of Medication
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________
	☐ High BP ☐ Diabetes ☐ Thyroid ☐ Cholesterol ☐ Arthritis ☐ Anxiety ☐ Pain ☐ Heart ☐ Vitamin ☐ Anti-coagulant ☐ Anti-Inflammatory ☐ ______________________

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY

☐ **I currently do not take any medications or supplements**

______________________________ ______________________________

Patient Signature Date