BAYCARE CLINIC®

Patient Name: _____

Date of Birth: _____

Pharmacy _____

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Food or Drug Allergies (note reaction): _____

_____

_____

_____

Latex Sensitivity? ☐ Yes ☐ No

CURRENT MEDICATION LIST

(List all current medications – both prescription and over the counter.
Include any vitamins, herbs, nutritional supplements, or recreational drugs that you routinely use.)

MEDICATION	DOSE	HOW OFTEN	Reviewed (✔) CLINIC STAFF ONLY					
			Date	Date	Date	Date	Date	Date
EXAMPLE: *Frosty*	*10 mg*	*every morning*	___/___/20___	___/___/20___	___/___/20___	___/___/20___	___/___/20___	___/___/20___
		Initials of Reviewer:						