9 Do you drink alcoholic beverages?..... Yes No

10 Have you used heroin, cocaine, marijuana, and other such drugs?..... Yes No

11 If you have any disease, condition, or problem not listed above, please explain

WOMEN

1 Are you pregnant?..... Yes No

2 Are you nursing?..... Yes No

3 Are you taking birth control pills?..... Yes No

I certify that to the best of my knowledge the above information is complete and accurate.

Signature of Patient or Guardian

Date

PERSONAL MEDICATION RECORD

Name: Date of Birth:

Allergies:

Physician: Physician Phone #

Pharmacy: Pharmacy Phone #

Name of Medication (Prescriptions, over-the-counter, eye drops, supplements, patches, herbals, inhalers implanted pumps)	**Dose of Medicine** (Example: one 20mg, tablet)	**How Often Do You Take This Medication?** (Example: three times a day, at bedtime)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		