Patient Label

Other Physicians, Medications, and Supplements

Please list all physicians you have seen during the last year including phone numbers and addresses.

Doctor:	Address:	Phone Number:

Please list all medications you are currently taking including the dosage and frequency per day.

Name of Medication:	Dosage:	Frequency (how many times per day):
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please list any and all vitamins/supplements you are currently taking including the dosage and frequency per day.

Name of Supplement	Dosage:	Frequency:	Purpose:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

If additional space is needed, use the back of this form.