PLEASE LIST ANY/ALL PRESENT MEDICATIONS PRESCRIBED TO YOU:
(PLEASE PRINT CLEARLY)

Name: _____ Date: _____

NAME OF MEDICATION	DOSAGE	CONDITION	PRESCRIBED BY
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

PLEASE LIST ANY OTHER SUPPLEMENT/VITAMINS/MINERALS/HERBS/HOMEOPATHICS/OILS/ETC. NOT RECOMMENDED BY DINKELMANN HEALTH CENTER, THAT YOU ARE CURRENTLY TAKING:

1	8
2	9
3	10
4	11
5	12
6	13
7	14