WHOLE FAMILY HEALTH, LLC

PATIENT MEDICATION AND SUPPLEMENT CHART

PATIENT NAME: _____ DOB_____ Age_____

Today's Date	**Medications (Rx & OTC)**	Dose	Purpose	Date Started

Today's Date	**Vitamins, Supplements & Herbs**	Dose	Purpose	Date Started

ALLERGIES: Please list any known allergies to medications, foods, pollens, metals, etc.

_____

_____

_____

OTHER:

I have a pace maker. yes___ no___

I have a bleeding disorder. yes___ no___

I am pregnant or could become pregnant. yes___ no___

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