



List all your medicines in the chart below including prescription and non-prescription drugs such as aspirin, antihistamines, vitamins, and/or supplements. Note how often you are taking each one, if it is a prescription, who the prescribing physician is, and for any that do not seem to be working or are causing you any problems, jot down the common side effects or unwanted feelings or symptoms.

**Medications taken:**

Medication Name:	How Often Taking:	Prescribing Physician:	Side Effects / Notes:
_____ <input type="radio"/> Prescription <input type="radio"/> Non-prescription			
_____ <input type="radio"/> Prescription <input type="radio"/> Non-prescription			
_____ <input type="radio"/> Prescription <input type="radio"/> Non-prescription			
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_____ <input type="radio"/> Prescription <input type="radio"/> Non-prescription			

My name: \_\_\_\_\_