

Patient Health and Medication Update

Patient Name: _____

Do you have any specific health or dental concerns today? Yes or No

If yes, please explain _____

Have you been hospitalized since your last visit here? Yes or No

If yes, please explain _____

Please list the medications that have been prescribed by your doctor:

Name of Medication	How Much and How Often?	Why Do You Take It?

Please list the medications that you have selected on your own (also called “over-the-counter” or OTC). These might include medicines for pain or headache (Tylenol, Motrin IB, Advil), stomach problems (Maalox, Pepto Bismol, Zantac), cough or cold symptoms (Robitussin, Dimetapp, Sudafed), allergies (Benadryl), etc.

Name of Medication	How Much and How Often?	Why Do You Take It?

Please list the herbs or other all-natural supplements that you are taking (such as ginseng, St. Johns wart, Saw Palmetto, Bilberry, etc):

Name of Herb/Supplement	How Much and How Often?	Why Do You Take It?

Do you like to drink grapefruit juice? Yes or No

If Yes, how often? _____

Do you like to drink cranberry juice? Yes or No

If Yes, how often? _____

Do you regularly take any type of vitamins(s)? Yes or No

If yes, explain: _____

Patient Signature: _____ Date: _____