Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Name Address Phone

Please list all prescription and over the counter medications, herbal supplements and vitamins you are taking.

Name Dose When started/Why

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The information I have provided is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medication, whether it be prescription or over the counter.

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Signature Date

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Medical History Update

Date/Initial Changes

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