CURRENT - MEDICATIONS FROM OTHER PHYSICIANS

Patient Name:	**Date:**

Who is filling out this form? □ **Patient** □ **Interpreter** □ **Family Member** _____
□ **Friend/Other**_____

** List medications for all visit related problems that are NOT prescribed by Dr. Woodcock. **
(Attach separate paper if necessary)

Medication	Dosing of Medication.	Time(s) you take medication.	Doctor prescribing medication.	Reason you take the medication. (IE: Pain, Headache, Depression, Anxiety, etc.
SAMPLE Ibuprofen	10 mg	2 in am 1 at bedtime	Dr. Sam Smith - or - Dr. Smith	Pain

DO YOU HAVE ALLERGIES OR MEDICATION REACTIONS? ?

☐ YES ☐ NO

IF YES, WHAT ARE YOUR ALLERGIES AND WHAT IS/ARE THE REACTIONS?

Please include any seasonal allergies, skin irritants, Brand - vs- Generic medications, medication reactions, or sensitivities.

Name:

Allergy:	**Reaction:**