Drug History Form

Please fill out the following form to the best of your ability, as the order that you began taking each drug, along with drug interactions are critical to your health and well-being. If more room is needed, please continue on 2nd page.

CURRENT DRUGS

Name of Drug	Dosage	When started taking	When stopped taking	Who prescribed to you	For what symptoms

PAST DRUGS (NO LONGER TAKING)

CURRENT DRUGS

Name of Drug	Dosage	When started taking	When stopped taking	Who prescribed to you	For what symptoms

PAST DRUGS (NO LONGER TAKING)