Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_

ELECTRONIC HEALTH RECORDS (EHR) DRUG LIST

Are you currently taking any medications: Yes No

Please list all your meds (be specific) with dosage. If you have a list we can copy it.

Are you allergic to any medication? Yes No

Please list the medication you are allergic to:

Please list problem caused by that reaction:

Do you currently smoke? Yes No Daily Occasionally

Have you ever been a smoker? Yes No

Do you use any other form of tobacco: Yes No

EMAIL:

Mobile Phone:

Home or Work Phone: