Crystal Community ENT• Patient Medications

Name:_____ Date: _____

Dear Patient: To meet all new government requirements we must have the complete information of your medicine. Thank you for your help with this.

* Please list **ALL** of your medications. Include Prescription & Over the Counter Medications
Vitamins, Minerals, Herbal Supplements

Medication Name & Strength	Dose	Why you take
(Examples): Lisinopril 10mg daily	**2 x day**	**Hypertension**
Tylenol PM 325mg	**1 x day at night**	**for Sleep**

Drug Allergies: Please list drug name and reaction

_____

_____

_____

_____

_____