# 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. Copies of list will not be accepted.

* 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** |
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Drug Allergies: Please list drug name and reaction

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