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TODAY'S DATE:

Name: \_\_\_\_\_ AGE: \_\_\_\_\_  
Address \_\_\_\_\_  
City: \_\_\_\_\_  
State: WA Zip: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_  
LIST ANY SPECIALIST SEEN: \_\_\_\_\_

**CURRENT LIST OF ALL MEDICINES**

PLEASE INCLUDE ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL AND ASPIRIN; ANY VITAMINS OR SUPPLEMENTS; AND ANY OTHER PREPARATIONS SUCH AS MYLANTA, PEPCID, ETC.

PLEASE LIST:

**MEDICATION    DOSAGE    HOW MANY & HOW OFTEN TAKEN**

**EXAMPLE:**

**TYLENOL    325 MG    2 TABLETS THREE TIMES PER DAY**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

PLEASE CONTINUE ON ANOTHER PAGE IF NEEDED