Interactions

Doctor Name
Clinic Name
Clinic Address
City, State Zip

Name:

Email Address:

Phone number:

Please list by name all prescription medications you are presently taking (include dosage if you know it):

1.
2.
3.
4.
5.

Please list by name any over the counter medications you are taking (include dosage if you know it):

1.
2.
3.
4.
5.
6.

Please list by name any supplements, vitamins or herbs you are taking (include dosage if you know it):

1.
2.
3.
4.
5.
6.

I the undersigned am providing the above for informational purposes only.

Print Name

Date

Signature