# MEDICATIONS & SUPPLEMENTS

Please list all of the pharmaceutical drugs, over-the-counter medications, supplements, nutritional drinks, and herbal supplements you have used *in the past six (6) months*. Use additional pages or bring these items with you to the consultation if you prefer.

| | Currently take? | | Dose, Form, Frequency* | What condition do you take this for? | Are you happy with the effects? Do you experience any side effects? |
|---|---|---|---|---|---|
| | YES | NO | | | |
| **Prescription Medications** | | | | | |
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| **Over-the-Counter Medications** (e.g., antacids, laxatives, aspirin, Tylenol, Advil, Motrin, Aleve, cough drops, cough syrups, etc.) | | | | | |
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| **Vitamin/Mineral Supplements or Nutritional Drinks** (e.g., energy drinks, protein shakes, etc.) | | | | | |
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| **Herbal Supplements** (please list all herbs included if a formula) | | | | | |
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*DOSE is how many milligrams or units; FORM is capsule, tablet, powder, liquid, etc.; FREQUENCY is how many times per day you take it.