

PRESCRIPTION MEDICATION & SUPPLEMENT DATA SHEET

(Examples are used)

Patient Name: _____ Date: _____

Pharmacy Information:

Name: _____

Phone: _____

Location: _____

Allergies (Please list food, drug, environment, etc.): _____

Current Prescription Medications

| Name | Strength | Dosing Instructions |
|----------------|----------|---------------------------------------------|
| Example: Lasix | 20mg | Once a day or divided and given twice a day |
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Current Supplements (*For fish oil supplements, please include EPA/DHA mg)

| Name | Strength | Dosing Instructions |
|------------------|----------|---------------------------|
| Example: Calcium | 500mg | One tablet in the morning |
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Laboratory Information: If you choose to have blood tests drawn outside of Fox Valley Wellness Center please provide the name and telephone number of the lab you use.

Lab Name: _____

Phone: _____