Medication Intake Form

Name: _____ **Date:** _____

Various health concerns can sometimes be caused by the intake of medication. It is important for your overall health and the maintenance of that health that we get a complete understanding of your medication history. Please fill out this form as completely as possible.

1. What medication are you currently taking and for what time frame have you been taking it?

   What is it for?

   _____ _____

   _____ _____

   _____ _____

   _____ _____

2. What medication have you been on in the past and for what time frame did you take it?

   What was it for?

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. Have you ever taken antibiotics? ❑ yes ❑ no

   How many times in your life have you taken them? ❑ 0-5 ❑ 6-10 ❑ more than 10

   When was the last time you took them? _____

4. Did your doctor follow-up with instructions on how to re-establish normal flora after the antibiotic regime was over? ❑ yes ❑ no

   If yes, what were the instructions? _____

   _____

   _____

over

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5. If you are a woman, have you ever taken birth control pills? ❑ yes ❑ no
   How long are/were you taking them? _____
   Are you currently taking them? ❑ yes ❑ no
   Did you ever stop taking them? ❑ yes ❑ no
   If so for how long did you stop? _____

6. If you are a man, have you ever taken Viagra or other like medicine? ❑ yes ❑ no
   If yes, are you currently taking them? ❑ yes ❑ no
   If yes, for how long? _____

7. Do you currently take vitamins or other health supplements? ❑ yes ❑ no
   If so, what are they? _____

   _____

   Where do you get them from?
   ❑ Health Food Store ❑ Direct Mail ❑ Other _____

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