Medications & Supplements

Name: ________________________ Date: ___________

Please list all of the pharmaceuticals, over-the-counter medications, supplements, nutritional drinks and herbal supplements you have used regularly in the past six (6) months.

	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					
Over-the-Counter Medications (e.g., antacids, laxatives, aspirin, Tylenol, Advil, Motrin, Aleve, cough drops, cough syrups, etc.)					

trinity herbs

	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			
Vitamins, Minerals, Supplements and Nutritional Drinks (e.g., energy drinks, protein shakes, etc.)					
Herbal Supplements (please list all herbs included if a formula)					

*DOSE is how many milligrams or units; FORM is capsule, tablet, powder, liquid, etc.; FREQUENCY is how many times per day you take it.