

CURRENT MEDICATION UPDATE

Please list ***all current medications*** including prescription, over the counter, and any vitamin supplements:

Please list any ***allergies*** you have to prescription or over the counter medications **or any food allergies:**

Please ***list the date*** of your last cycle: _____

OR indicate one of the following: menopause hysterectomy

Please indicate one of the following: smoker non - smoker

****Medication History Patient Consent: By signing below, I agree that Susan Futayyeh, MD may request and use my prescription medication history from other healthcare providers or third party pharmacy payors for treatment purposes.****

Please list any existing medical conditions:

Signature : _____ ***Date:*** _____