Name	Date of Birth
Allergic to: **List & describe reaction**	
Doctor/s	

List all medicines you are currently taking. Include **prescriptions** (eg: pills, inhalers, creams, shots, nitroglycerin),
Over-the-counter medications (eg: aspirin, antacids, **Viamins, Supplements**), **Herbals** (eg: ginseng, gingko).

NAME OF MEDICATION	DOSE	FREQUENCY	NOTES Reason for Taking