



## Information about you:

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Blood type \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Email \_\_\_\_\_

Prescription Medications - List any prescription medication you take regularly. (Use pencil)

Type	Start Date	Name of Medication Brand Name/Generic Name (if available)	Dose you take (mg. units, puffs, drops)	When do you take it? How many times a day? Morning and night? After meals? With meals?
Prescription				
Over-the-counter				
Herbs				
Dietary Supplements				
Homeopathic Remedies				