Carp Ridge EcoWellness Centre
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Medication History

Please fill out this form indicating prescription or natural and over the counter medication that you have taken.

Patient Name: _____ **Date:** _____

Do you have any anaphylactic allergies? _____

Please check any of the following medications that you are taking or have taken in the past 2 years:

□ aspirin/Tylenol	□ pain relievers	□ sleeping pills	□ tranquilizers
□ antacids	□ laxatives	□ diurectics	□ birth control pills
□ radiation	□ chemotherapy	□ epi pen	□ appetite suppressants

Any known allergies or drug sensitivities? _____

Number of times on antibiotics in past 10 years? _____

Number of times on corticosteroids in past 10 years? Topical _____ Oral _____

Name of Drug	Dose	Duration	Reason for Taking / Results Experienced
Please list any prescription medications you have taken in the <u>past 2 years</u>			
Please list any supplements/ herbal medicines / natural health products that you are currently taking			