

Drug/Supplement List

W.A. Shrader, Jr., MD

Patient Name: _____ Date: _____

Please list below any drugs you take on a regular basis

Drug Name	Dose	Times per day	Prescribed by	Length of time taken

List all vitamins you take (may use the back of this form for others)

Name of supplement	Dose if known	Times per day	Length of time taken

Do you have allergies to any drugs?

Drug	When	Type of reaction