



MEDICATIONS LIST
Dr. Carol A. Lee-Collins

Name _____

Date _____

Please complete this form and bring to your appointment.

Please list all medications you are taking, including over-the-counter products (e.g., aspirin, antacids, vitamins and herbals).

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Medication: _____ Dosage _____ Direction _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____

Drug Allergies _____ Adverse Reactions _____