MRN: |__|__ | - |__|__| - |__|__ | - |__|	**Subject ID:** |__|__ |__|__| - |__|__ |__|__|__|__| **Visit Date:** __ __/__ __/__ __ __ __

Record all medications currently being taken as well as any newly prescribed medications.

1. Are you currently taking any medications, supplements or vitamins? Yes ☐ No ☐

Medication/Supplement/Vitamin Name	**Dose/Unit** Examples: 100 mg, 1 puff, 50 mL	**Frequency** Examples: 1x day, as needed	**Route**	**Start Date** MMM/DD/YYYY (eg. Jan 01 2015)	**Stop Date** MMM/DD/YYYY (eg. Jan 01 2015) *Please indicate if ongoing. If ongoing, please leave the date blank.*	**New Script** **(for clinic staff use only)**
2.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
3.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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4.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
5.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
6.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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8.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
9.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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11.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
12.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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14.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
15.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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17.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
18.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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20.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐
21.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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24.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐

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26.			☐ oral ☐ inhaled ☐ eye drops ☐ ear drops ☐ nasal spray ☐ topical ☐ intravenous ☐ intramuscular ☐ sublingual ☐ other If other, specify: _____	MMM _____ DD _____ YYYY_____	☐ on-going MMM _____ DD _____ YYYY_____	☐