Current Medications/Supplements

The Hetrick Center

Date Completed: ____/____/____

☐ Please check if you have attached your own list.

Medication or Supplement name:	Dosage:	Frequency:	Date you started:
1.			
2.			
3.			
4.			
5.			
6			
7			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

List any known allergies you have had to any medications:

_____

_____

_____

_____

_____

Please keep us updated of any changes in medications or supplements that you are taking by reprinting and submitting this form.