

Wesley Johnson, MD

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please list below the medications and supplements you are taking.

	<u>Dosage</u>	<u>Amount</u>	<u>Reason</u>
1.	_____ /	_____ /	_____
2.	_____ /	_____ /	_____
3.	_____ /	_____ /	_____
4.	_____ /	_____ /	_____
5.	_____ /	_____ /	_____
6.	_____ /	_____ /	_____
7.	_____ /	_____ /	_____
8.	_____ /	_____ /	_____
9.	_____ /	_____ /	_____
10.	_____ /	_____ /	_____
11.	_____ /	_____ /	_____
12.	_____ /	_____ /	_____
13.	_____ /	_____ /	_____
14.	_____ /	_____ /	_____
15.	_____ /	_____ /	_____

ALLERGIES:

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Tobacco Use: How Much? \_\_\_\_\_ How Long? \_\_\_\_\_ Quit? \_\_\_\_\_

Alcohol Use: How Much? \_\_\_\_\_ How Long? \_\_\_\_\_ Quit? \_\_\_\_\_