Medication Details

Name: ______________________________Please list all medications you are currently taking.

Medications

Medication (Name)	Dose	Duration (Months/years)	Purpose (What is it for?)
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________
_____________________	____________	____________	_________________________

Injections

Do you receive regular injections from your General Practitioner (Doctor)? **Yes No**

Injection	Dose	Duration	Purpose
____________________	____________	_____________	_________________________
____________________	____________	_____________	_________________________
____________________	____________	_____________	_________________________

Complimentary Medications

Do you take/use any vitamins or alternative medications?

Medication	Purpose
______________________________________	____
______________________________________	____
______________________________________	____

Recreational Drugs

____

____

Adverse reactions

Have you ever had a reaction to any medications? **Yes No**

Medication	Reaction
______________________________________	____
______________________________________	____
______________________________________	____

I, _____________________________________ do not have the medication details required for this appointment, I will disclose medication detail before my next dental appointment.

Signature:_____________________________ **Date**:______________________________________