EDMUND KRASINSKI, JR., D.O., F.A.C.G., P.L.L.C.

MEDICATIONS

Patients Name: _____Date of birth:_____

Are you allergic to any medications? _____ Yes _____ No (no known allergies)

If yes, which medications and what type of reaction:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

PLEASE LIST ALL MEDICATIONS/HERBS THAT YOU ARE CURRENTLY TAKING

MEDICATION AND REASON FOR TAKING	DOSE	TIMES A DAY

Patient's Signature: _____ Date: _____