ALLERGIES/REACTIONS TO MEDICATIONS: (rash, hives, swelling, shortness of breath)

CURRENT PRESCRIPTIONS/OVER THE COUNTER MEDICATIONS/ NON PFEIFFER NUTRIENTS

MEDICINE/Route	DOSE/How often	DATE STARTED	LAST TAKEN	REASON / RESPONSE	D/C'd *(ofc. use)*	*RN* *INITIALS/* *Date*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Name of Current Primary Physician: ____________________________________ Phone # ______________________________

Name of Current Psychiatrist: ____ Phone # ______________________________

Name of Current Therapist: ____ Phone # ______________________________

MEDICATION FAILURES:

DO YOU SWALLOWS PILLS ? YES – NO

INTERESTED IN COMPOUNDING? YES - NO

ANTIHISTAMINES/INHALERS IN PAST 3 MONTHS? YES - NO

ALLERGY SHOTS/DROPS IN PAST 3 MONTHS? YES - NO

TOTAL DAILY ZINC:_____________________________

RN SIGNATURE:_________________________

Patient Name: ___________________________ DOB ___/___/_____ Date of Service: _____________________