

Date: _____

MEDICATION HISTORY

Patient Name: _____

**** ATTN NEW PATIENTS: Dr Lakin does not prescribe or manage chronic/long term pain medications. This practice refers to the recommended Pain Clinics on our website for prescribing and management.**

DRUG ALLERGIES

1. _____ 3. _____

2. _____ 4. _____

PRESCRIPTION MEDICATIONS: Please list all medicines or drugs being taken NOW that were **PRESCRIBED BY A DOCTOR** (include what you take for chronic conditions, birth control, etc).

MEDICINE NAME	DOSAGE	HOW OFTEN TAKEN
---------------	--------	-----------------

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

NON PRESCRIPTION MEDICATIONS: Please list medicines or drugs you sometimes take that were **BOUGHT WITHOUT A PRESCRIPTION** (such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins).

MEDICINE NAME	DOSAGE	HOW OFTEN TAKEN
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1. _____

2. _____

3. _____