Advanced Medicine and Aesthetics

Patient Name: _____ DOB: _____

UPDATED MEDICATION AND ALLERGY LIST

Medications

Name of Medication Indicate if pills, ointment, drops, etc.	**Dose each time** i.e. mg., drops, tsp., etc	How many do you take at a time?	How often do you take this medication?	UTD

Allergies

Please list any **allergies** or adverse reactions you have had.