Date: _____

Medications

Name: _____D.O.B. _____/_____/_____

I. Drug Allergies/Adverse Reactions

Drug Name (Brand & Generic)	Reaction

II. Medications (oral/inhaled/injected/topical/over-the-counter)

Drug Name (Full Name)	Dose(ml/mg)	How often Taken	Reason for Taking

III. Medical Conditions:

_____
_____
_____
_____
_____
_____
_____

IV. Primary Care Physician(PCP):_____

V. Specialists: _____

Please bring this form to your next visit or fax to (630) 232-9936.

Lawrence L. Johnson, M.D., S.C.
3310 W. Main St., Suite 115
St. Charles, IL 60175