

Patient Name _____

I do not take any medications/vitamins/supplements.

Pain: (List dosage/frequency)

- | | | |
|--|--------------|-----------------|
| <input type="checkbox"/> Tylenol | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Percocet / Endocet / Tylox (Oxycodone + Tylenol) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Dilaudid (Hydromorphone) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Duragesic patch (Fentanyl patch) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Hydrocodone (Lortab/Norco/Vicodin) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> MS Contin (Morphine sulphate) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Oxycodone (OxyContin) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Other: _____ | Dosage _____ | Frequency _____ |

Anti-Inflammatories: (List dosage/frequency)

- | | | |
|--|--------------|-----------------|
| <input type="checkbox"/> Advil/Motrin/Ibuprofen | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Aleve (Naprosyn/Naproxen) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Aspirin | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Celebrex | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Mobic (Meloxicam) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Diclofenac sodium (Voltaren) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Prednisone and/or Steroid Pack | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Other: _____ | Dosage _____ | Frequency _____ |

Muscle Relaxers: (List dosage/frequency)

- | | | |
|---|--------------|-----------------|
| <input type="checkbox"/> Amrix / Flexeril / Fexmid (Cyclobenzaprine) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Skelaxin (Metaxalone) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Soma (Carisoprodol) | Dosage _____ | Frequency _____ |
| <input type="checkbox"/> Other: _____ | Dosage _____ | Frequency _____ |

Vitamins/Supplements:

- | | | |
|-------|--------------|-----------------|
| _____ | Dosage _____ | Frequency _____ |
| _____ | Dosage _____ | Frequency _____ |
| _____ | Dosage _____ | Frequency _____ |

Other Medications / Topicals / Patches:

- | | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

List all allergies that you may have: _____

Check if you are taking any medications for conditions listed below.

- | | |
|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Medications | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diuretics (water pill) | |

Patient Signature: _____ **Date:** _____