

Prescription Medications

Start Date	Name of Medicine Brand name Generic name too if available	Prescribed By	Dose (mg, units, puffs, drops)	When Do You Take It? How many times per day? Morning and night? After meals?	Purpose Why do you take it?	Important Comments (e.g. danger signs, side effects, drug-drug, drug-food interactions, stopped taking*)	Stop Date	Monitoring Required (e.g. lab test every _____ weeks)	Notes Date reviewed; Date Updated

Medical Conditions

- asthma heart disease diabetes high blood pressure
 cancer kidney disease vertigo other _____

Questions*

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| Have you ever taken Viagra? | | Yes | No |
| Have you ever taken steroids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever used addictive pain medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*We ask these questions in an attempt to provide you the best and most appropriate audiological services that we can. These substances are known to cause hearing loss and tinnitus.

Over-the-Counter Medications

- | | |
|---|---|
| <input type="checkbox"/> Allergy relief, antihistamines | <input type="checkbox"/> Herbals, dietary supplements |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Aspirin/other pain, headache, or fever | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Cold/cough medicines | <input type="checkbox"/> Vitamins, minerals |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Energy drinks containing ginseng | <input type="checkbox"/> |

Information about you

Your name: _____

Address: _____

Birth Date: _____

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