



Medications and Supplements

Orville R. Weyrich, Jr, PhD, NMD, BCN, ABAHP

Patient Name: _____ Date of birth ____/____/____

Today's Date ____/____/____

Please review the current entries and, if an item has been stopped or changed, check the appropriate history box and provide the approximate date. Also fill in missing information or correct errors.

Add any additional prescription medications, over-the-counter medications, and dietary supplements you currently use, as well as any that you have started, stopped, or changed within the past month. Indicate who prescribed or recommended each item (which may be "self"). Attach additional pages as needed.

History/Change MM/DD/YY	Medication / Supplement Name & Brand	Prescriber / Recommender	Dose / Route / Frequency	Reason for Use (Purpose)
☐ Started ☐ Stopped ☐ Changed / /				
☐ Started ☐ Stopped ☐ Changed / /				
☐ Started ☐ Stopped ☐ Changed / /				
☐ Started ☐ Stopped ☐ Changed / /				
☐ Started ☐ Stopped ☐ Changed / /				