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NAME: _____ DATE: _____

PLEASE LIST ALL PHARMACEUTICAL MEDICATIONS
THAT YOU ARE TAKING
Also add any ACID-Stopping medications that you take, even if 'over-the-counter'.

Name of drug
Dose
Reason for taking it
How long you have been taking it?
Have you experienced side effects that you believe to be caused by this medication?

Med	Reason	Known Side Effects	Possible Drug Interactions

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Note: this information will not be used to diagnose, treat or cure disease.