The New York Aesthetic Consultants, LLC

Universal Medication Form

Patient Name: _____ Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Do you have any Allergies to Medication? □ **NO** □ **YES** If yes, list allergies and reactions to medication: _____

_____

Do you currently take any Medications? □ **NO** □ **YES** If yes, **please list all medications that you are currently taking.** Include: eye drops, inhalers, contraceptives, patches that contain medication, over-the-counter medications (e.g., aspirin, antacids) and dietary/herbal supplements (e.g., vitamins, gingko biloba). Also include medications taken as needed (e.g., nitroglycerin).

FOR OFFICE USE ONLY

Date	Name of Medication & Dose (e.g., mg, drops)	Directions (e.g., am, pm)	Reason for taking/ Prescribing MD name	Date Stopped	Medication given in office	Contra-indicated?
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
						Y N
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