Alexander N. Stadnyk, M.D.
6624 Fannin, Suite 1450
Houston, TX 77030

Patient Name: _____
Date of Birth: _____

MEDICATION HISTORY

Date: _____ Information provided by: _____ Relationship to patient: _____

MEDICATION ALLERGIES: [ ] None [ ] Yes, please list:

[ ] Have Medicines with Me [ ] List Given to Office Staff [ ] I DO NOT Take Any Medicines
[ ] unable to obtain medication information, reason: _____

NAME OF MEDICATION	DOSE/STRENGTH	HOW OFTEN TAKEN	REASON FOR USE

NON-PRESCRIPTION MEDICATIONS/SUPPLEMENTS	
Type of medication:	**How Often?**
For allergies:	
For sleep:	
For stomach upset/diarrhea:	
Vitamins, herbal supplements:	
Other:	

What medications do you take for pain relief?	Are they effective? [ ] Yes or [ ] No
Have you taken any of the following in the past 2 weeks? If yes, circle as appropriate: **Aspirin, Coumadin, Plavix, Ticlid**	Date of last dose:
When was your last **pneumonia vaccination?** (If unknown, check unknown) When was your last **flu vaccination?** (If unknown, check unknown)	Date: _____ [ ] Unknown Date: _____ [ ] Unknown

Patient's Signature: _____

OFFICE USE ONLY

Signature of Physician or designee: _____ Date: _____