

PRESENT MEDICAL CONDITION

Name _____

Date _____

MEDICATIONS YOU ARE CURRENTLY TAKING AND/OR DISCONTINUED

In **Column A** check all medications you are currently taking.

In **Column B** check all medications you have discontinued.

SCHEDULE II	A	B	C
Amphetamine			
Oxycodone			
Oxycontin			
Percocet			
Percodan			
Other			
SCHEDULE III	A	B	C
Ambien			
Ativan			
Baclofen			
Elavil			
Imipramine			
Trazadone			
Tylenol w/codeine			
Valium			
Vicodin			
Xanax			
SSRI	A	B	C
Effexor			
Paxil			
Prozac			
NSAID	A	B	C
Acetaminophen			
Alleve			
Aspirin			
Ibuprofen			
OTHER	A	B	C