

Current medications list.

(Please include vitamins, herbs or supplements.)

As an extra please also list those which you were taking but stopped recently or those which you had reactions to in the past.

Substance **Prescribed by whom** **Reason for prescription** **Taken since... until** **Comments.**

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Typical diet

(Please list all foods that you normally eat.)

DIET:

MOSTLY

SOMETIMES

Breakfast.....

Lunch.....

Snacks.....

Dinner.....

Spices:

Drinks