

4. ✳ **Star** the medications you have used at least once in the past.
 Underline the medications that have helped your medical conditions.
O **Circle** the medications you currently use to treat your medical conditions.

Advil	Aspirin	Buprenex	Codeine	Darvocet	Demerol
Dilaudid	Duragesic	Elavil	Feldene	Fentanyl	Fierocet
Flexeril	Ibuprofen	Klonopin	Lorcet	Lortabs	Morphine
Motrin	Naprosyn	Neurontin	Norflex	Oxycodone	Oxycotin
Paxil	Percocet	Percodan	Prosac	Relafen	Restoril
Skelaxin	Soma	Toradol	Tylenol	Tylenol #3	Tylox
Ultram	Valium	Vicodin	Voltaren	Xanax	Zoloft

Others : _____

5. Are you currently experiencing any of these conditions?

	Yes	No	How much? _____
Weight Loss (Last 6 Months)	___	___	
Anxiety or Stress	___	___	
Problems with Sleep	___	___	
Fatigue	___	___	
Change in Bowel Movement	___	___	
Blood in Stool/Dark Stool	___	___	
Blood in Urine	___	___	
Nausea/Vomiting	___	___	
Chronic Cough	___	___	
Fevers/Night Sweats	___	___	
Urinary Tract Disorders/Infections	___	___	
Tuberculosis	___	___	
Morning Joint/Muscle Stiffness	___	___	
Joint Pain/Swelling	___	___	
Heart Murmur	___	___	
Rheumatic Fever	___	___	
Arterial Graft Surgery	___	___	
Chest Pain	___	___	
Palpitations	___	___	
Shortness of Breath	___	___	
Increased Thirst	___	___	
Fainting/Dizziness/Vertigo	___	___	