WEST MICHIGAN DERMATOLOGY
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MEDICATION HISTORY & REVIEW OF SYSTEMS

Name: _____ **Date of Birth:** _____

****NAME OF YOUR PREFERRED PHARMACY:** _____
PHONE #: _____ **Address of Pharmacy:** _____
City: _____ **Cross street (if known)** _____

MEDICATIONS: (Please enter all current medications & supplements with dosage & frequency).
Add attached sheet if necessary.
Some medication information can be imported electronically from your pharmacy.
Do we have permission to initiate an electronic import of your medication history? ☐ **Yes** ☐**No**

Do you require the use of any of the following: *if yes, please circle*

Coumadin (Warfarin) Aspirin, Plavix (Clopidogrel),
Pradaxa (Dabigatran Etexilate) Xarelto (Rivaroxaban)

MEDICATION/SUPPLEMENT	DOSAGE	FREQUENCY

Allergies:

Do you have any of the following allergies?: *If yes, please circle*

Latex Lidocaine Epinephrine Clindamycin

Please list any other allergies	Reaction