

Name

**Current Medications:** Please list your current medications (include vitamins and herbs).

Name of Drug	Dose/Strength (mg)	Number of pills/tabs	Times per day

**Past Medications:** Have you ever taken any of the following?

Medication	Length of time taken	Reactions/Why were medications stopped?
Aspirin		
Tylenol (pain)		
Tylenol with codeine		
Darvon/Darvocet		
Vicodin		
Ultram		
Celebrex		
Indocin		
Motrin/Ibuprofen		
Naprosyn/Alieve		
Allopurinol		
Colchicine		
Prednisone/Cortisone		
Actemra		
Actonel		
Arava		
Azulfidine		
Boniva		
Benlysta		
Cimzia		
Enbrel		
Fosamax		
Humira		
Imuran/ Azathioprine		
Methotrexate		
Plaquenil		
Prolia		
Reclast		
Remicade		
Rituxan		
Simponi		
Other:		
Other:		
Other:		