Vital Health
ENDOMETRIOSIS
CENTER

Medication and Supplement Summary

Name: _____ **Date of Birth:** _____ **#1 Date/Initials:** _____

#2 Upated Date/Initials: _____ **#3 Upated Date/Initials:** _____ **#4 Upated Date/Initials:** _____

Hormones/Birth Control:

NO CHANGE	Medication Name:	Dose / Strength (e.g. 1 mg):	How many times per day?:	What is the reason you take this?
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime	
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime	

Pain Medications (Including Over the Counter meds and ALL secure prescriptions):

NO CHANGE	Medication Name:	Dose / Strength (e.g. 1 mg):	How many times per day	What is the reason you take this?
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	

Other Medications: - if needed, ask for second page if needed

NO CHANGE	Medication Name:	Dose / Strength (e.g. 1 mg):	How many times per day	What is the reason you take this?
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	

Supplements / Vitamins / Homeopathic Therapies / Chinese Herbs:

NO CHANGE	Supplement Name:	Dose / Strength (e.g. 1 mg):	How many times per day?:	What is the reason you take this?

New Allergies or Side Effects? ☐No ☐ *Yes* - If Yes, please describe:

Pharmacy Name, Location and Tel #: REQUIRED	*Compounding Pharmacy Name, Location and Tel #:*

PATIENT EXAMPLE of how to complete form

Name:_____ **#1 Date/intiails:** _____

Hormones/Birth Control:

NO CHANGE	Medication Name:	Dose / Strength (e.g. 1 mg):	How many times per day?:	What is the reason you take this?
	Estrace Tablets	1 mg	1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime	
	Vivelle Dot	0.1 mg	1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime	

Pain Medications (Including Over the Counter meds):

NO CHANGE	Medication Name:	Dose / Strength (e.g. 1 mg):	How many times per day?	What is the reason you take this?
	Norco	10/325	1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
	Percocet	10/325	1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	

Other Medications:

NO CHANGE	Medication Name:	Dose / Strength (e.g. 1 mg):	How many times per day?:	What is the reason you take this?
	Synthroid	75 mcg	1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
	SR T3 compound	7.5 mcg	1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
	Borox Suppositories		1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	
			1x 2x 3x or 4x at what time of day _____ am / pm or at bedtime every 4h 6h 8h or 12h	

Supplements / Vitamins / Homeopathic Therapies / Chinese Herbs:

NO CHANGE	Supplement Name:	Dose / Strength (e.g. 1 mg):	How many times per day?:	What is the reason you take this?
	DIM Insinase			

New Allergies or Side Effects? ☐No ☐ *Yes* - If Yes, please describe:

I notice that I get a rash on my neck when I take the Synthroid.

Pharmacy Name, Location and Tel #:	*Compounding Pharmacy Name, Location and Tel #:*
Even if you are not currently working with a local pharmacy, please provide the information for the local pharmacy that you want to work with if we need to call in a prescription for you.	