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MEDICATIONS AND SUPPLEMENTS

M Cheikin MD

Name: Date:

List CURRENT medications and supplements you are taking on a regular or intermittent basis

Medication/ Supplement	Date Started (Approx)	Purpose	Dose and Frequency	Effectiveness	Side Effects	Leave Blank

☐ Continued on Back

List DISCONTINUED medications and supplements you have taken over the past 2 years

Medication/ Supplement	Date Started (Approx)	Date Stopped	Reason for Stopping	Side Effects	Leave Blank

☐ Continued on Back