SUMMIT SKIN & VEIN CARE

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Diplomates of the American Board of Venous & Lymphatic Medicine

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(816) 554-SKIN (7546) or (816) 554-VEIN (8346)
(816) 554-9470 Fax

Patient Name:_____ **DOB:**_____ **Date:**_____

Please list **ALL** known prescriptions, over the counter, herbal /vitamins/minerals and dietary supplements with dosage, frequency & route of administration.

Please **PRINT** on the form and bring completed list with you to the appointment.

(If any changes occur please let the staff know, so we are able to correctly update medication list.)

Prescriptions/Over the counters/ Herbals/ Vitamins/Minerals & Dietary Supplements	Dosage	Frequency: How often it is taken.	Route of Administration (oral / injected / patch)
Example: Azithromycin	Example: 20 mg	Example: 2 times daily	Example: Oral

Initial Date Initial Date Initial Date Initial Date