DUNSON
DENTAL • DESIGN

MEDICATION INFORMATION

1100 Peachtree St. N.E. Suite 680

Atlanta, Georgia 30309

Please list the medications that have been prescribed by your doctor:

Name of Medications	How much and how often?	Why do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the medications that you have selected on your own (also called "over-the-counter" or OTC). These might include medicines for pain or headache (Tylenol, Motrin, Advil), stomach problems (Maalox, Pepto Bismol, Zantac), cough or cold symptoms (Robitussin, Dimetapp, Sudafed), allergies (Benadryl), etc.

Name of Medications	How much and how often?	Why do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the herbs or other all-natural supplements that you are taking (such as Ginseng, St. Johns wort, Saw Palmetto, Bilberry, etc.):

Name of Herb/Supplement	How much and how often?	Why do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you like to drink grapefruit juice? YES NO

If yes, how often? _____

Do you like to drink cranberry juice? YES NO

If yes, how often? _____

Do you regularly take any type of vitamin(s)? YES NO

If yes, how often? _____

Patient/Guarantor Signature*: _____ **Date:** _____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. *

Revised 12-2021