Dr. Leonard F. Anglis, D.D.S

Patient Medication List

Date of birth:____/____/____ **Date list received:_____**

Patient name:_____

Allergies:_____

Please list contact information for your Dr.(s)_____

☐ ***Check this box if currently <u>not</u> taking medications*** **Pharmacy I use: _____**

☐ ***Check this box if currently <u>not</u> taking supplements or vitamins of any kind***

Date Started	Current medications Including over the counter medications, vitamins and herbal supplements	Strength	Times taken per day	Reason for taking	Dr. who prescribed medication