DERMATOLOGY ASSOCIATES of Kingsport

Medication List

Please complete and bring to your appointment. Thank you.

Name: _____ Date of Birth: _____ Date: _____

Pharmacy name: _____ Pharmacy phone #: _____

List below any medication allergies:

Are you currently taking any blood thinners? Yes or No

List below all medications you are currently taking including any over-the-counter medications, herbal supplements or vitamins:

Name of Medication:	Dosage:	How often per day: