Patient's Name:_____

Please List ALL MEDICATIONS you are currently taking: (Prescription and Over the Counter)

Medication Name	Dosage	Frequency
What type of Glucose Monitor do you use?		
Do you have an insulin pump? If so what brand.		

Please List All Allergies

Allergies ☐YES ☐NONE	Type of Reaction

☐ **By checking this box, I am stating that I currently do not take Prescription or over the counter Medications.**

Patient Signature **Date**