Dermatology East

Please List Your Medical Conditions (*e.g,.* Diabetes, Heart Disease, etc.)	**Please list your medications or Provide your list**			
To the best of your ability, please group your medications with your conditions	**Medication**	**Dosage (*e.g.*, mg)**	**Frequency (*e.g.*, 2 x day)**	**Route (*e.g.*, oral)**

Please list your current over-the-counter, herbals, vitamins, minerals and dietary supplements:

MEDICAL ALLERGIES

Are you allergic to numbing medicine, *i.e.*, Lidocaine or Epinephrine: Rubber / Latex:

Please list other medication allergies: