

## Medication and Allergy List

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  

Last
First
Middle or Maiden
Date of Birth

Please list **all** prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

(If additional space is needed then please copy this page)

Medication	Strength	Dose	How many times a day
<i>Examples:</i> Claritin D	10mg	One pill	Once daily
St. John's Wort	400mg	One	Once daily

### \*\* Allergies \*\*

Medication <small>(Include prescription, over-the-counter and/or vitamins)</small>	Describe Reaction

Have you ever had an allergic reaction to:     Contrast Dye     Iodine     Shell Fish

What type of reaction did you have:     Hives     Shortness of breath     Other: \_\_\_\_\_

Additional Comments and/or Information: \_\_\_\_\_

### Pharmacy Information

Pharmacy Name \_\_\_\_\_ Phone Number (    ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_