Today's Date: _____

Patient's Name: _____ DOB:_____

Name of Medication / Vitamin / Herbal, etc.	Dosage? (ex. 80 mg)	How often do you take it? (ex. Twice a day)	Route? (ex. By mouth)

ALLERGIES (medications): _____

Reaction: _____

ALLERGIES (other): _____

Latex Allergy ☐ Yes ☐ No