PATIENT NAME **DATE OF BIRTH**

NAME & LOCATION OF PREFERRED PHARMACY

ALLERGIES OR BAD REACTIONS (MEDICATION OR NON-MEDICATION)		
☐ I have no known allergies		
ITEM	**REACTION**	**SEVERITY**
Example: Latex	*Shortness of Breath*	*Severe*
Example: Penicillin	*Rash*	*Mild*

MEDICATION NAME	STRENGTH	FREQUENCY	PRESCRIBING DOCTOR
Example: Celebrex	*200 mg*	*1 tablet/3 x/day*	*John Doe. M.D*

"OVER THE COUNTER REMEDIES"	
NAME	**STRENGTH & FREQUENCY USED**

Please attach an additional sheet if more space is needed.

143891 12/11