



Current Medication List and Allergy Information

Date: _____

Name: _____ Date of Birth ____ / ____ / ____

Please list ALL medication and vitamin supplements you are currently taking.

Check here if NO medication/supplements taken _____

Medication/Supplement Name	Dosage	How Often? (once, twice daily, etc)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Drug/Latex Allergies:

Check here if NO allergies _____

Allergy to

Reaction

_____	_____
_____	_____
_____	_____