MEDICATIONS & ALLERGIES

PATIENT INFORMATION		
Name:	**Date of Birth:**	**Today's Date:**
Preferred Pharmacy:		**Pharmacy's Phone #:**

MEDICATION ALLERGIES	
ALLERGY	**WHAT HAPPENS**

MEDICATIONS YOU ARE TAKING CURRENTLY		
MEDICATION	**DOSAGE**	**SPECIAL NOTES**

If you need more space, please continue listing medications on the back.