



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

Complete this form and bring medications in original pharmacy containers to office visit:

**Allergies**

Are you allergic to any medications?  
Medication

Yes       No  
Reactions

_____	_____
_____	_____
_____	_____
_____	_____

Other allergies (foods, adhesive tape, iodine, latex, etc):

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

Medication

Dosage

How often?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Vitamins and Supplements:**

Vitamin/Supplement

Dosage

How often?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_