Medication and Allergy List

Today's Date:_____

Patient Name:_____ _____
Last First Middle or Maiden Date of Birth

Please list ***all*** prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

(If additional space is needed then please copy this page)

Medication	Strength	Dose	How many times a day

** Allergies **

Medication (Include prescription, over-the-counter and/or vitamins)	Describe Reaction

Have you ever had an allergic reaction to: ❑ Contrast Dye ❑ Iodine ❑ Shell Fish

What type of reaction did you have: ❑ Hives ❑ Shortness of breath ❑ Other:_____

Additional Comments and/or Information:_____

Pharmacy Information

_____ (_____)_____
Pharmacy Name Phone Number

_____
Address City State Zip Code

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Please return completed form to the appropriate physician's office.