PATIENT MEDICATION and ALLERGY UPDATE LIST

Patient Name: _____ **Date of Birth:** _____
(Please Print Name)

MEDICATIONS

Please list all medications which you are taking, including any over the counter medications, supplements (such as vitamins, natural supplements, calcium, etc.)

MEDICATION	DOSAGE	TIMES PER DAY

ALLERGIES

Please list all allergies to medications. (If you are taking medication for allergies, please be sure to list that medication in the above Medication List.

ALLERGY/MEDICATION	REACTION OR SIDE EFFECT

Are you allergic to or have a reaction to eggs ☐ Yes ☐ No
Are you allergic to or have a reaction to shellfish ☐ Yes ☐ No
Are you allergic to or have a reaction to LATEX ☐ Yes ☐ No

Pharmacy Name: _____ **Phone** #: _____
Address: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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For Office use Only: Entered into EMR : Date: _____ By:_____
Print Name
Signature: