Patient Name_____ **Date**_____

Allergies

Name of Substance(drug or food)	Type of reaction(such as rash, ...)

Current Medications

Please include birth control, creams, eye drops, insulin, inhalers, injections, over-the-counter medication, vitamins, herbs, minerals, supplements,etc.

Start Date	Medication	Dosage	Times/Day	Reason	Comments

Pharmacy Name_____Telephone_____

Location_____