

## Patient Medication and Allergy History

*In order for us to obtain a complete medical history, it is important for you to fill out this form.*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Are you taking ANY medications now?    NO                       Yes  (If yes, please list below)

*Please list below all prescription medications, over-the counter medications, herbs, vitamins, or food supplements you are **CURRENTLY TAKING FOR THIS CONDITION ONLY.***

Name of Medication	Dosage	How often taken

*Please list below all prescription medications, over-the counter medications, herbs, vitamins, or food supplements you have taken and/or tried in the past **for this condition BUT HAVE DISCONTINUED.***

Name of Medication and Dose	How long tried	Reason not taking

*Please list below all other prescription medications, over-the counter medications, herbs, vitamins, or food supplements you are **currently** taking.*

Name of Medication	Dosage	How often taken

### ALLERGIES/SENSITIVITY:

Do you have allergies?    NO                       Yes  (If yes, please list below)

*Please list allergies to medications, food, chemical, and environmental*

Allergy/Sensitivity	Type of reaction

*If you need more room, please list additional medications/allergies on back of this page. Thank you!*

Entered: \_\_\_\_\_

Date: \_\_\_\_\_