Allergy & Asthma Center, P.C.

330 S. Garden Way #150
Eugene, OR 97401
541-485-0316
Fax 541-431-0317

330-C NW Elks Dr.
Corvallis, OR 97330
541-754-7170
Fax 541-758-0707

Candice M. Rohr, M.D.
Alice H. Chou, M.D.
Alalia W. Berry, M.D.

Current Medications, Medication Allergies, and Medical Problems

Patient Name	
Date of Birth	

DRUG ALLERGY: (There is space to document additional drug allergies on Page 2.)

I reacted to the following medication:

☐ penicillin ☐ sulfa ☐ aspirin ☐ other (specify)_____

Date of reaction(s)_____

I had the following reaction:

☐ rash ☐ swelling ☐ hives ☐ trouble breathing ☐ shock

☐ other (specify):_____

Medication History:

List all current medications (including prescription and over-the-counter medication(s) that you are currently taking:

Name	Strength	Frequency

PHYSICIAN USE:

Date Reviewed with Patient:												

See Other Side

Patient's Name_____**Birthdate**____/____/____

Medical Problems:
List all past and current medical problems including surgeries and hospital admissions:

Date	

Additional Drug Allergies:

Date	**Drug Name**