Allergy & Asthma Center, P.C.

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Current Medications, Medication Allergies, and Medical Problems

Patient Name			
Date of Birth		**Date**	

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