Medications & Allergies

Please answer every question

*STAFF: ALL items in this form must be entered **MANUALLY**.*

PLEASE PRINT PATIENT'S LAST NAME

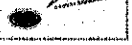
PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



ALLERGIES

Please mark any of these allergies you have:

I HAVE NO KNOWN MEDICATION ALLERGIES ⬭

Contrast or Iodine Allergy ⬭
Latex Rubber Allergy ⬭
Anaphylactic or Other Reaction to Anesthesia ⬭

MEDICATION ALLERGIES

Please list all medications or injections that have given you bad reactions.

If possible, include your reactions (e.g., hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath, etc.)

Medication or Injection	Reaction

Medication or Injection	Reaction

PRESCRIPTION MEDICATIONS

Please list all prescription medications you are currently taking.

(Alternatively, bring in an accurate list to your appointment.)

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

OVER-THE-COUNTER MEDICATIONS

Please list all over-the-counter medications you are currently taking.

(e.g., aspirin, Motrin, Tagamet-HB, vitamins, herbs, etc.)

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

PREFERRED PHARMACY

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For technical support, please contact PatientLink at Support@MyPatientLink.com.