**Patient Name**______________________________ **Date**________

**Allergies**

| Name of Substance(drug or food) | Type of reaction(such as rash, ...) |
|---|---|
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**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 |
|---|---|---|---|---|---|
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Pharmacy Name__________________________Telephone_________________________

Location____________________________________________________________________