ALLERGY & PRESCRIPTION MEDICATION LIST

Patient Name_____ Date of Birth_____

Allergies (***Please circle all that apply***): **No Known Drug Allergies**

Penicillin	Cephalosporin	Sulfa	Codeine	Tape/Adhesive
Metal	Latex	Aspirin	Iodine	

Other Antibiotics/Medicines_____

Local Anesthetic(s)_____

PRESCRIPTION MEDICATIONS:

Medication Name	Dosage	# of Times Taken a Day	Prescribing Physician

Please list anything else that you take on a regular basis(aspirin, etc.)_____

_____

I attest that the above information is true and correct and that I will report any changes on my next visit.

_____ _____

Signature of Patient/Authorized Agent Date

For Office Staff Only:

Reviewed by Dr. Rhodes on _____

Updated on_____