Please List the **names and dosage of all medications** you are taking (include regularly used over-the-counter medications/supplements).

____ Please check here if you are currently taking NO medications.

Medication Name **Dosage & Directions**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pharmacy Name _____ Phone_____

Street _____ City/Zip_____

Are you allergic to any of the following medications:

Allergen **REACTION**

Penicillin_____

Sulfa_____

Latex_____

IV contrast dye _____

Cipro_____

Codiene_____

Levaquin_____

Macrobid_____

Others (please list) _____

_____ check here if you are **NOT** allergic to any medications