Print Form

SHARP Rees-Stealy Medical Centers

Medications and Allergies

Patient Name:

Birth Date:

Medications

Please provide the information requested below for every prescription medication, over-the-counter medication, vitamins or any supplement you are currently taking. The required information can be found on the label printed on the medication bottle. If needed, please use the second page of this form.

Name of medication, indicate if pills, ointment, drops, etc.	Dose each time i.e. mg., drops, tsp., etc.	How many do you take at a time?	How often do you take this medication?	For what medical condition is this medication prescribed?
Example *Hydrochlorthiazide*	***Example*** *25 mg.*	***Example*** *1*	***Example*** *Once each day*	***Example*** *Hypertension*

Allergies

Please list any allergies or adverse reactions you have had:

Medication or substance which caused the allergic reaction	What kind of reaction did you experience?	When did this reaction first occur?

If you need additional space, please use the following:

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