# ***MEDICATIONS AND ALLERGIES***

**PATIENT NAME:** _____ **DATE:** _____

## CURRENT MEDICATIONS

***Including prescription drugs, vitamins, hormones, aspirin, Tylenol, ect*.**

| Name of Medication | Strength | Taken How Often | Length of Time on Medication |
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## ALLERGIES

***ARE YOU ALLERGIC TO ANY MEDICATIONS? _____YES _____NO IF YES, PLEASE LIST:***

| Name of Medication | Type of Allergic Reaction |
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********** LATEX ALLERGY _____ YES _____ NO **********