

Patient Known Allergies and Medical Conditions

Note: This document is formatted for printing. Please fill in the text fields prior to printing.

Patient Information

Patient Full Name:

Date of Birth:

Date of Record:

Known Allergies

Please list any food, drug, or environmental allergies along with the reaction severity and typical symptoms.

Allergen / Trigger	Reaction Severity (Mild, Moderate, Severe)	Symptoms / Description
<input type="text" value="e.g., Penicillin"/>	<input type="text" value="e.g., Severe"/>	<input type="text" value="e.g., Hives, anaphylaxis"/>
<input type="text" value="e.g., Peanuts"/>	<input type="text" value="e.g., Severe"/>	<input type="text" value="e.g., Swelling, shortness of"/>
<input type="text" value="e.g., Latex"/>	<input type="text" value="e.g., Mild"/>	<input type="text" value="e.g., Contact dermatitis"/>
<input type="text" value="Other"/>	<input type="text"/>	<input type="text"/>

Active Medical Conditions

Please list all currently diagnosed or ongoing medical conditions.

Medical Condition	Date of Diagnosis	Current Status / Notes
<input type="text" value="e.g., Type 2 Diabetes"/>	<input type="text" value="e.g., 2018"/>	<input type="text" value="e.g., Managed with diet and"/>
<input type="text" value="e.g., Hypertension"/>	<input type="text" value="e.g., 2020"/>	<input type="text" value="e.g., Controlled with medication"/>
<input type="text" value="e.g., Asthma"/>	<input type="text" value="e.g., Childhood"/>	<input type="text" value="e.g., Uses rescue inhaler as needed"/>
<input type="text" value="Other"/>	<input type="text"/>	<input type="text"/>

Emergency Contact Information

Primary Contact Name:

Relationship to Patient:

Phone Number:

Authorized Signature

I verify that the above-listed allergies and medical conditions are accurate to the best of my knowledge.

Signature of Patient or Representative:

Date Signed: