

Patient Allergy and Medication History Form

Please fill out this form completely. This document is designed for your medical records and printing purposes.

1. Patient Information

Patient Full Name:	<input type="text"/>	Date of Birth:	<input type="text" value="MM/DD/YYYY"/>
Phone Number:	<input type="text"/>	Today's Date:	<input type="text" value="MM/DD/YYYY"/>

2. Known Allergies

Please list any allergies to medications, food, or environmental factors (e.g., latex, contrast dye) and the reaction experienced.

Allergen (Medication, Food, or Substance)	Reaction (e.g., Rash, Swelling, Difficulty Breathing)	Severity (Mild, Moderate, Severe)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Current Medications

Please list all prescriptions, over-the-counter medications, vitamins, and herbal supplements you are currently taking.

Medication Name	Dosage (e.g., 50mg, 1 tablet)	Frequency (e.g., once daily, as needed)	Reason for Taking
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Emergency Contact Information

Contact Person Name:	<input type="text"/>
Relationship to Patient:	<input type="text"/>
Phone Number:	<input type="text"/>

Patient or Guardian Signature: _____

Date Signed: _____