



Proliance Surgeons, Inc.

CURRENT MEDICATIONS & ALLERGIES

In our efforts to improve patient care and safety, it is required that you complete this list with any current medications you are taking including the dosage, how often those medications are taken and the reason for taking them. Please include any known allergies to medications, latex, iodine, food, or metals.

Patient's Printed Name: _____

Date of Birth: _____

I) CURRENT MEDICATIONS:

Primary Care Physician: _____

Name of Medication	Dosage	How often	Reason

II) OVER THE COUNTER MEDICATIONS: INCLUDING HERBALS AND DIETARY SUPPLEMENTS

Name of Medication	Dosage	How Often	Reason

III) ALLERGIES:

Name of Allergies	Reaction	Name of Allergies	Reaction

Patient's Signature: _____

Pharmacy Name: _____

Date: _____

Pharmacy Phone #: _____

Updated on (date): _____

Pharmacy Fax #: _____

Patient initials

MA initials