# Patient Medication Record

Pharmacy Name/Phone #: _____

Allergies/sensitivities (drugs, anesthesia, IV, X-ray dyes, latex, tape, other)_____

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| 1) | | 4) | |
| 2) | | 5) | |
| 3) | | 6) | |

| Medication | Dose | Frequency | Date Started | Date Discontinued |
|---|---|---|---|---|
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Patient Name: _____ Date of Birth: ____/_____/_____