Allergies & Medication List

NAME: _____ DOB: _____ DATE: _____

(This form is not optional. Your medications and supplements **must be** *handwritten* per Silverton Health.)

Medication Name (Prescription, Supplement or OTC medication)	**Strength** (Write strength of each pill, drop or spoonful, ect)	**Dose** (How much of the medication are you taking?)	**Frequency** (How often or when do you take the medication?)	**Route** (How are you taking this medication?)
Example: *Tylenol*	*500mg*	*2 tablets*	*8am & 4pm*	*orally*

Drug or Non Drug Allergies

☐ **No Known Drug Allergies**

Allergy Source (Medication, Food or other)	**Reaction** (Hives, Sneezing, Rash, other)	**Sensitivity** (Mild, Moderate, Severe)

Smoking Status: ☐ **Current Smoker** ☐ **Former Smoker** ☐ **Never Smoker**