Name: _____ **Pharmacy Name & Location:** _____

_____

Medications: Please list all medications you are currently taking.

(Include prescriptions, herbs, supplements and over the counter)

Name	Dosage	Frequency

Allergies:

Allergy to Latex Gloves? No Yes Reaction: _____

Allergy to Band Aid Adhesive? No Yes Reaction: _____

Allergy to Contrast or Iodine? No Yes Reaction: _____

Problems with Anesthesia? No Yes

Family history of problems with Anesthesia? No Yes

Allergic to Medications

Please list the medications you are allergic to:

Medication	Reaction it causes