PROLIANCE ORTHOPEDIC ASSOCIATES

*Specializing in What Moves You*

# 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 |
|---|---|---|---|
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## II) OVER THE COUNTER MEDICATIONS: INCLUDING HERBALS AND DIETEARY SUPPLEMENTS

| Name of Medication | Dosage | How Often | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## III) ALLERGIES:

_____

**Patient's Signature**: _____ Pharmacy Name:_____

**Date:** _____ Pharmacy Phone #:_____

Updated on (date): _____ Pharmacy Fax #:_____

_____ _____

Patient initials MA initials