Updegraff Clinic for Allergy and Dermatology

MEDICATION LIST

(Please Print)

Today's Date:			
PATIENT INFORMATION			
Patient Name	**Date of Birth:**	**Age:**	**Sex:** ☐ **M** ☐ **F**

ALLERGIES Including latex, bandages, medications, food, and other.	**Reaction**

MEDICATIONS	
Name of Medication	**How often do you take the medication?**

The above information is true to the best of my knowledge.	
_____ Patient/Guardian Signature	_____ Date

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