Allergy & Asthma Center

of Southern Oregon, PC

Patient Medication List

Name: _____ DOB: _____ Date: _____

Drug Allergies/Intolerances: _____

Prescription Medication	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
Over-the-Counter Medication	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
What medications were stopped for Allergy Testing?	Dose & Frequency	For What Condition	Currently Taking?
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN
			Yes No PRN