Allergy & Asthma Center
of Southern Oregon, PC
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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