Patient Printed Name: ______________________________________

MRN *(for office use only)*: ______________________________

Date of Birth: ______ / ______ / ________

PATIENT REPORT OF CURRENT MEDICATIONS

DATE: ______________________

List all current medications – both prescription and over the counter in any dosage or form.

Include any vitamins, herbs or nutritional supplements taken routinely or when needed.

Med/Food Allergies:

☐ **YES**, I have allergies to medications and/or foods

☐ **NO**, I do not have allergies to medications and/or foods

If you checked yes, please complete the next page detailing your allergies

MEDICATION	DOSE	HOW OFTEN
	EXAMPLE:	
Frosty	***10 mg***	***every morning***
STAFF INITIALS		

Upon transfer of medication information into the EMR, discard this form in a confidential destruction bin.

40027.1
Rev. 2/20/2023

BayCare Clinic®

Patient Printed Name: ______________________________

MRN *(for office use only)*: ______________________

Date of Birth: ______ / ______ / ________

PATIENT REPORT OF MEDICATION/FOOD ALLERGIES

DATE: ________________________

MEDICATION/FOOD	REACTION
STAFF INITIALS	

Upon transfer of medication information into the EMR, discard this form in a confidential destruction bin.