

ASTHMA AND ALLERGY SPECIALISTS

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NAME: _____ AGE: _____ DATE: _____

Please list ALL medications you are currently taking. INCLUDE medications that were prescribed by other physicians. Remember to include ALL blood pressure medications, sleeping pills, or ANY OTHER MEDICATIONS, PRESCRIBED AND OVER THE COUNTER?

NAME DOSE/HOW OFTEN REASON FOR TX. APPROX. START DATE

PRESCRIPTION DRUGS:

NON-PRESCRIPTION DRUGS:

EYE DROPS:

NOSE SPRAYS:

VITAMINS:

SKIN CREAMS, OINTMENTS, LOTIONS:

DRUG ALLERGIES:

PENICILLIN: Y N
SULFA: Y N
ASPIRIN: Y N
NOVACAINE: Y N

DESCRIBE REACTION TO DRUG

OTHERS: