PATIENT MEDICATIONS AND ALLERGIES

Patient Name: ___________________________________ **Date:** ____________

To help us provide you with the best care while you are here at Virginia Mason, please complete this form to the best of your ability. Much of the information is on the label of your prescription bottles or can be obtained from your pharmacy or doctor's office. Be sure to include ALL kinds of medications such as Vitamins, Herbal Medications, Supplements and Pain Relievers.

Medications

☐ I take no Prescription Medications, Non-Prescription or Other Medications.

Name of Medication	Dosage	When do you take it?
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Allergies

YES	NO	
☐	☐	I have one or more drug allergies.
☐	☐	I am allergic to latex.
☐	☐	I am allergic to tape.
☐	☐	I am allergic to IV Contrast (X-Ray Dye).

I am allergic to:	Reaction
1	
2	
3	
4	
5	

VMMC FORM 901878 (08-08)

NOT A PART OF THE PERMANENT MEDICAL RECORD