## Virginia Allergy & Asthma Center

MEDICATIONS

Patient: _____ DOB: _____ Date: _____

** Please list below ALL medications that you have taken over the last 30 days for any condition, include herbs and vitamins. **

| Name of Medication | Strength or Dose | How Many per Day/Week | What side effects (if any) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |
| 16. | | | |
| 17. | | | |
| 18. | | | |
| 19. | | | |
| 20. | | | |
| 21. | | | |

**MEDICATION ALLERGIES**

| Name of Medication | Type of Reaction | Age at Time of Reaction |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

Additional Information:

_____

_____

_____

Patient Signature: _____ Date: _____