PAIN DIAGNOSTICS AND INTERVENTIONAL CARE

PATIENT MEDICATION RECORD

Patient's Name: _____ **Date of Birth:** _____

ALLERGIES: (Include Reaction) _____

_____

Do you have ALLERGIES to:

LATEX? YES NO	SHELLFISH? YES NO	IV Dye (Iodine)? YES NO

******PLEASE LIST ALL MEDICATIONS THAT YOU TAKE ON AN DAILY BASIS OR ON AN AS NEEDED BASIS AS WELL. INCLUDE ANY OVER-THE-COUNTER MEDICATIONS SUCH AS VITAMINS, MINERALS, PAIN MEDICATIONS (SUCH AS IBUPROFEN, ALEVE, TYLENOL). INCLUDE MEDICATIONS THAT ARE TAKEN BY MOUTH, INJECTED, INHALED, PLACED IN EYES/NOSE OR APPLIED TO YOUR SKIN.**

NAME OF MEDICATION	DOSE or STRENGTH OF MEDICATION	FREQUENCY