*Place label here/or patient full name/account number*

# ALLERGY & MEDICATION LIST

## ALLERGIES

| Allergy | Reaction |
|---|---|
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***No Known Drug Allergies: Yes _____ No ______***

## MEDICATIONS

**Date: _____________________ Reconciled by: ___________**

| Medication Name | Type<br>Rx = Prescription<br>OTC = Over the Counter, Vitamin/Mineral, Herb, Dietary Supplement | Dose | Frequency | Route<br>(Oral, topical, injection, inhalation) |
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## Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

**Please check response: Yes _____ No _____**

**Patient/Guardian Signature: ________________________________________________**

**Print Patient Name: _________________________________ DOB:______________________**