Center for Dermatology Care

Medication/Allergy List

Patient Name:		Date of	Birth:	
**Please list ALL Prescribed Medications, Supplements, and over-the-counter Meds and Creams Circle One Below				
Medication/Supple	ement Name	Dosage	Frequency	Route of Administration
				Pill Cream Patch Injection
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Allergies: Please list all med	lication food and envi	ronmental alle	rgies AND reactions	Fill Cream Fatch injection
Allergies: Please list all medication, food, and environmental allergies AND reactions				
Item	Reaction		Item	Reaction
Patient Signature: Date:				
Staff Initials & Date:				