MDVIP-AI

MEDICATION HISTORY FORM

Patient Name _____ **Date of Birth** _____

Medical Record # _____ **First Visit Date** _____

Instructions For Medication Allergies: Fill-in Medication name and add the reaction that occurred (If unsure of the reaction, enter "unsure")

***Don't Miss the Last Page (Antibiotic History for the last 12 months) *Very Important**

Common Medication Allergies: Check if Allergic

Allergens / Adverse Reactions

___ I.V. Contrast for (___ CAT scan / ___MRI): _____

___ Latex: _____

___ Tape or Band aid adhesive (non-latex): _____

___ Wound glue: _____

___ Nickel: _____

___ Penicillin: Type (___ Amoxil) / ___ Unk.): _____

*Reaction type: ___ Anaphylaxis/ ___ Hives / ___ Flat rash / other: _____

Other Medication Allergies / Adverse Reactions

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

_____/ _____

Medications or Supplements Currently Being Taken:

Instructions For Current Medications: Fill-in Medication or supplement name, milligram (or dose size) and frequency of dosing.

Medication Name	/	Dose size	/	Frequency
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	
	/		/	

Medication Name	Dose size	Frequency

Antibiotics Taken in the last 12 months:
