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RECORD FOR

Drug (Medication) Allergy

Patient Name: _____ Date of birth: DD / MM / YYYY

Patient Address: _____

This record is confirmed on DD / MM / YYYY by Specialist: _____ Signature: _____

DRUG ALLERGIES FOR ASSESSMENT

Drug	Reaction Date* and Type	Assessment Date and Type	Recommendation

DRUG SIDE EFFECTS AND INTOLERANCES

Drug	Reaction Date* and Type	Additional Notes

NOTES:

*If date of reaction is not known, state if it was less or more than five years ago.

If the patient information does not all fit on this page, attach another completed record and indicate number of pages here. Page ___ of ___