DALLAS CENTER FOR PELVIC MEDICINE: MEDICATION AND ALLERGY LIST

Today's Date:_____

Patient Name:_____ _____

Last Name First Name MI Date of Birth

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment

MEDICATION	STRENGTH	DOSE	How many times per day

****ALLERGIES****

MEDICATION (Include prescription, over the counter, and vitamins)	DESCRIBE REACTION

- **Have you ever had an allergic reaction to:** ☐ **Contrast Dye** ☐ **Iodine** ☐ **Shell Fish**
- **What type of reaction did you have:** ☐ **Hives** ☐ **Shortness of Breath** ☐ **Other** _____
- **Additional comments and/or Information**_____

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PHARMACY INFORMATION			
Pharmacy Name:		**Phone Number:**	
Address	**City**	**State**	**Zip code**