**MEDICATION / ALLERGY FORM**

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS FROM WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: ______________________________________________________________________________

Do you take any of the following: Plavix, Coumadin, Aggrenox, Pradaxa or an aspirin daily? YES NO

| **CURRENT MEDICATIONS – Please list any medications that apply to this visit. If you are not currently taking any medications, please check the "none" box.** ☐ **None** | | |
|---|---|---|
| **Name of Medication** | **Dosage** | **Frequency** |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |

| **MEDICATION/ALLERGY SENSITIVITY**<br>**List all medications allergic to:** ☐ **None** |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |

***To my understanding, this represents an accurate portrayal of my health history. I will inform Dayton Center for Neurological Disorders as changes or updates occur.***

______________________________________________________________________________

Patient Signature Date

______________________________________________________________________________

Patient Representative Signature Relationship Date